

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

10/10/77 SS

10/10/77 SS





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2> <h2 style="margin: 0;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 1.5em;">72 00502</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">SAMUEL ERNEST GILLET</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">JAN 21 1972 1 55 P</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">38 University Hospital</span>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">MD</span> B. COUNTY <span style="font-size: 1.2em;">B. CARROLL 5600</span>	
5. SEX <span style="font-size: 1.2em;">Male</span> 6. RACE <span style="font-size: 1.2em;">Col</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">LABORER</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">TENN</span>	
13. FATHER'S NAME <span style="font-size: 1.2em;">CURT GILLET</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">JULIA McCHAIN</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">?</span>		16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">228-63-8103</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">PNEUMONIA</span> (B) <span style="font-size: 1.2em;">CUA</span> DUE TO, OR AS A CONSEQUENCE OF: (C)	
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.2em;">DIABETES</span>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">5-DAYS</span> <span style="font-size: 1.2em;">1 MONTH</span>	
19A. DATE OF OPERATION <span style="font-size: 1.2em;">12-15-71</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">PVP - amputation</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">?</span>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location!)	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12-8</span> 19 <span style="font-size: 1.2em;">71</span> to <span style="font-size: 1.2em;">1-11</span> 19 <span style="font-size: 1.2em;">72</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">1-11</span> 19 <span style="font-size: 1.2em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.2em;">Peter W. Brall, MD</span>		23B. DATE SIGNED <span style="font-size: 1.2em;">1-11-72</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">PETER W. BRALL, MD</span>		23D. ADDRESS <span style="font-size: 1.2em;">UNIV. OF MD HOSP</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		24B. DATE <span style="font-size: 1.2em;">1-15-72</span>	
24C. NAME OF CEMETERY or CREMATORY <span style="font-size: 1.2em;">St Luke Cemetery</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Lyskville, Md.</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 18 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">P. E. E. Fisher, M.D.</span>	
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Lang. W. Haight</span>		ADDRESS <span style="font-size: 1.2em;">Lyskville, Md</span>	

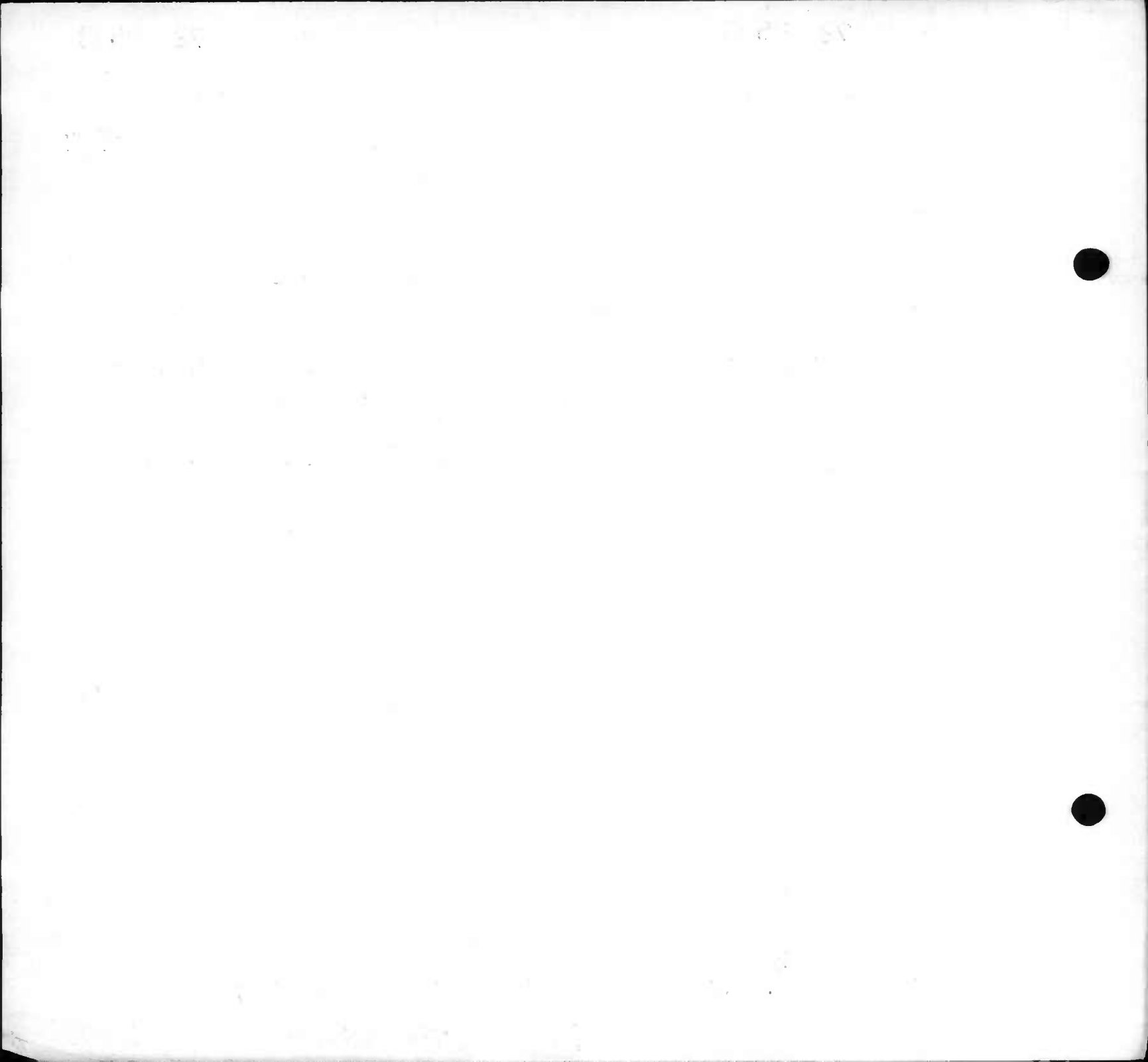
Adm. to Springfield 12/16/65

No fixed address.

ET

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-62/ 72 00503		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00503	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BESSIE ARGABRIGHT</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 12, 1972 7:47 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2 BALTO</b>		5. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL</b>		E. STREET AND NUMBER <b>814 TRAFALGAR ROAD</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/25/95</b>	9. AGE (In years last birthday) <b>76</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Hinkle Appleby</b>		14. MOTHER'S MAIDEN NAME <b>Mary Emma Eichelberger</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-46-7915</b>		17. INFORMANT <b>JOSEPH ARGABRIGHT</b> <b>814 TRAFALGAR ROAD, BALTO.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>MYOCARDIAL INFARCTION</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>30 MIN</b>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCLEROTIC HEART DISEASE</b>		<b>@ 20 YRS</b>	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>DEC. 2</b> 19 <b>71</b> to <b>JAN. 12</b> 19 <b>72</b>		that (I) (we) last saw the deceased alive on <b>JAN 12</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.	
23A. SIGNATURE <b>Harry A. Spald</b>		23B. DATE SIGNED <b>1/12/72</b>		23C. PHYSICIAN'S NAME (Type) <b>HARRY A. SPALD</b>	
23D. ADDRESS <b>MARYLAND GENERAL HOSP, BALTO., MD</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 17, 1972</b>	
24C. NAME of CEMETERY or CREMATORY <b>Dulaney Valley Memorial</b>		24D. LOCATION (City, town, or county) <b>Cockeysville, Maryland</b>		24E. LOCATION (State) <b>Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>E. E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>JOHN J. BROWN</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00504

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>John Desellem</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 13 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>43 So. Baltimore General</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 13 72 8:05 P.M.</b>	
6. SEX <b>male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>10-13-87</b>		10. AGE (in years last birthday) <b>84</b>	
11. BIRTHPLACE (State or foreign country) <b>Penn</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lumbermill worker</b>	
15. MOTHER'S MAIDEN NAME <b>JACOB</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes 4-25-18 3-10-19</b>	
17. SOCIAL SECURITY NO. <b>172-12-2258</b>		18. INFORMANT <b>BROTHER</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>412.4</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>1 13 72</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> DATE SIGNED <b>1/14/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-17-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Cedar Hill</b>		24D. LOCATION (City, town, or county) (State) <b>Ritchie Hwy BALTO. MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>HAHN Funeral Home</b>		ADDRESS <b>4200 Pennington</b>	

NO 35

35 0000

10

10

10

John Smith

10

10

10

10

X

10

10

X

X

10

10

10-13-87

10-13-87

U.S.A. 10-13-87

10-13-87

10-13-87

10-13-87

10-13-87

10-13-87

10-13-87

10-13-87

10-13-87

10-13-87

10-13-87

10-13-87

10

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00505</b>	
BIRTH NO. <b>72 00505</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>LANG, EILEEN</b>		2. DATE AND HOUR OF DEATH <b>1-13-72 9:20 P M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>35 Church Home + Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2609</b>	
5. SEX <b>F</b>		6. RACE <b>A W</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-4-1909</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		11. BIRTHPLACE (State or foreign country) <b>md.</b>	
13. FATHER'S NAME <b>J. Lazarus Schmalze</b>		14. MOTHER'S MAIDEN NAME <b>Henrietta Calendar</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-03-5599</b>	
17. INFORMANT <b>Conrad C. Lang</b>		ADDRESS <b>801 S. Dean St.</b>	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac Failure 20 to 25 hrs</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Acute myocardial Infarction for hrs</b> <b>Acute Pulmonary Edema</b> <b>Cardiac Arrhythmia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-13-1972</b> to <b>1-13-1972</b> that (I) (we) last saw the deceased alive on <b>1-13-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Ma. Elena V. Mangay</b>		23B. DATE SIGNED <b>1-13-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>MA. ELENA V. MANGAY</b>		23D. ADDRESS <b>100 N Broadway Baltimore, Md. 21231</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-17-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Oak Lawn</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>E. Taylor M.D.</b>	
25C. FUNERAL DIRECTOR <b>Thelma A. Hoffmann</b>		ADDRESS <b>3218 Hudson St.</b>	

1/21/72. Correction form from financial director Spe



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-625 72 00506		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00506	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>WAWRZY尼亚K. BENJAMIN</b>		2. DATE AND HOUR OF DEATH <b>1-13-72 2:53 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>21237 5300</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>NORTH CHARLES GEN. HOSP.</b> <b>49</b>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER <b>7928 3rd St.</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7-21-98</b>	9. AGE (In years last birthday) <b>73</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>POCAND</b>	
13. FATHER'S NAME <b>ROBERT WAWRZY尼亚K</b>		14. MOTHER'S MAIDEN NAME <b>FRANCIS GORALSKI</b>		12. CITIZEN OF WHAT COUNTRY	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> WW I		16. SOCIAL SECURITY NO. <b>213 10 1279</b>		17. INFORMANT <b>Admission Chart</b>	
18. <b>41019 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarct</b> (B) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Acute</b> <b>Yes</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Urinary Tract obstruction</b>		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) (Year) 1 (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12-18</b> 19 <b>71</b> to <b>1-13</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1-13</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Manankil</b>		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>RUPERTO MANANKIL</b>	
23D. ADDRESS <b>NORTH CHARLES GEN. Hosp</b>		23E. DEGREE		23F. DEGREE	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-17-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. LOCATION (City, town, or county)		24F. LOCATION (State)	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>W. E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>WALTER DABROWSKI</b>	
25D. ADDRESS <b>1005 DUNDALK AVENUE</b>		25E. ADDRESS		25F. ADDRESS	

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

10 11

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 00507	
S-416 72 00507				CERTIFICATE OF DEATH	
BIRTH NO.			1. NAME OF DECEASED (Type or Print)		
			IDA B. SILVERMAN		
2. DATE AND HOUR OF DEATH			Jan, 12, 1972 8:40 P M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE Maryland		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			B. COUNTY		
00 6516 Hartwait Street			C. CITY OR TOWN Baltimore		
			D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER 6516 Hartwait Street		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Nov. 3 1903	68	housewife
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			Boswell Pa.		
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
John Marshal			Sara Kendal		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS
no			218 12 2323		Sam Silverman 6516 Hartwait Street
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Coronary Thrombosis		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			Arteriosclerosis C.V. Dis 12 yrs		
			(C) Cerebrovascular Dis 10 yrs		
			Diabetes mell 10 yrs		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from April 19 62 to Dec 24 19 71, that (I) (we) last saw the deceased alive on December 24 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Stephen C. Mackowiak				1-13-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. Stephen Mackowiak				6714 Holabird Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-15-72		Oak Lawn Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 18 1972		WALTER DABROWSKI		1005 DUNDALK AVENUE	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

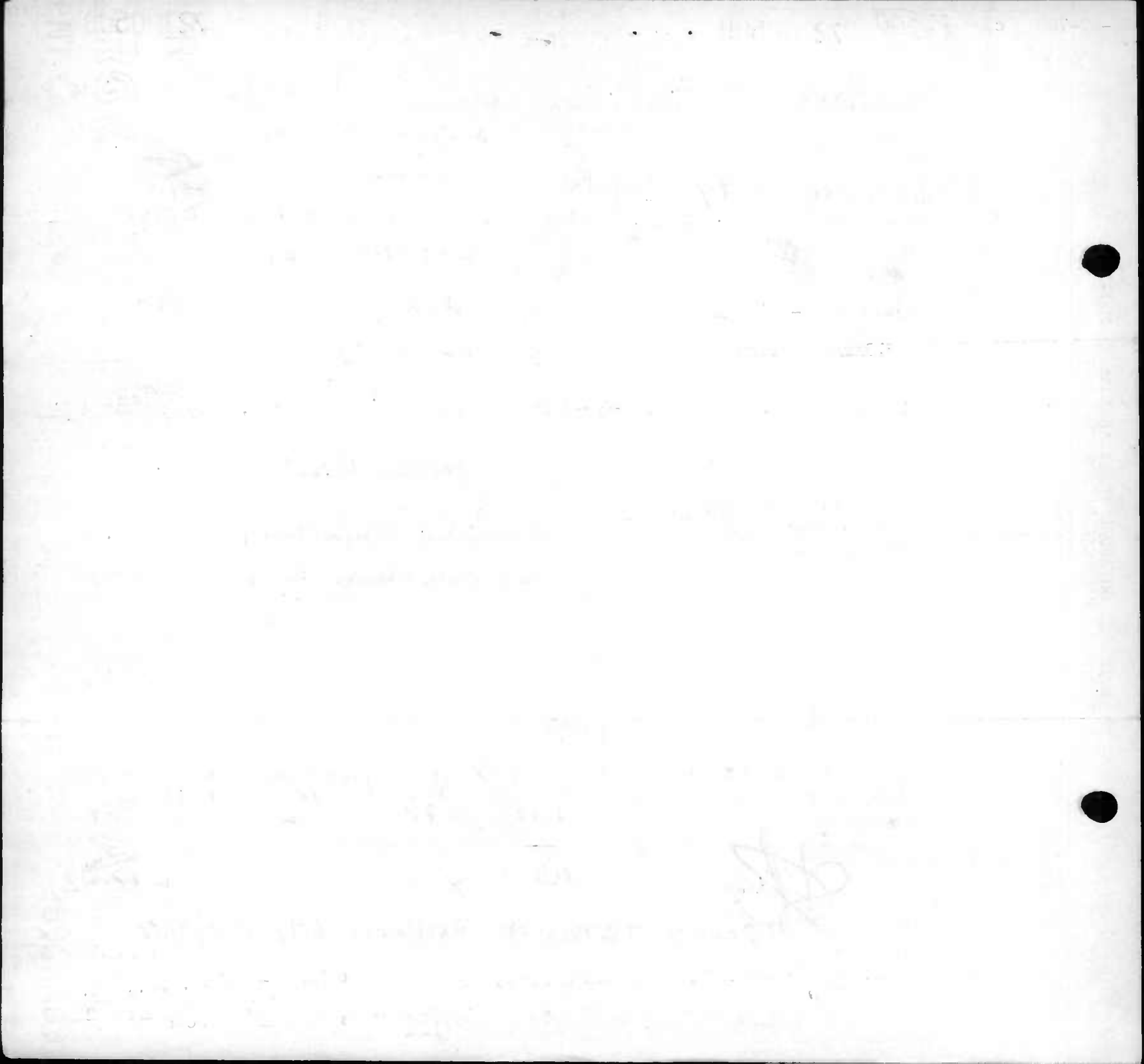
B-200 72 00508				DEPARTMENT OF HEALTH CITY OF BALTIMORE		REG. NO. 72 00508	
1. NAME OF DECEASED (Type or Print) <b>BIGGS Russell G.</b>				2. DATE AND HOUR OF DEATH <b>1/12/72 11:20 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2788</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>Small Hospital of Baltimore</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
CERTIFICATE AMENDED 2-25-72				E. STREET AND NUMBER <b>5220 Saint Charles Avenue</b>			
				F. CITY OR TOWN <b>Baltimore</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/7/197</b>		9. AGE (In years last birthday) <b>74</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter - Self Employed</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Pollis Pallard Biggs</b>				14. MOTHER'S MAIDEN NAME <b>Lottie Charlotte (Grannis)</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>212-07-0972B</b>		17. INFORMANT <b>Mrs. Minnie Biggs</b> ADDRESS <b>5220 St. Charles Avenue 15</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>593.21</b> <b>CAUSE OF DEATH</b> <b>Ventricular fibrillation &amp; cardiac arrest 2ary to Hypertension</b> <b>Uremia &amp; renal failure.</b> <b>accompanied massive R &amp; L pneumonia</b> <b>ASCD &amp; History of Myocardial infarction.</b> <b>General debilitation.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. DATE OF OPERATION				19A. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/4 1972</b> to <b>1/12 1972</b> that (I) (we) last saw the deceased alive on <b>1/12/72</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>H. Leveque</b>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>H. LEVEQUE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/15/1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md. Balto. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>James E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Loring Byers</b> ADDRESS <b>8728 Liberty Road 21133</b>			

1-25-72 - Correction form from Funeral Director. HRS

RELEASED ON APPROVAL BY MEDICAL EXAMINER  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print) <b>REED, Orlie L. Sr.</b>		2. DATE AND HOUR OF DEATH <b>1-12-72 2:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospital</b> <b>4940 Eastern Avenue Baltimore, Maryland 21224</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Owings Mills</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>301 Pleasant Ridge Drive 21117</b>	
5. SEX <b>M</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-23-1910</b>
9. AGE (In years last birthday) <b>61</b>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALESMAN - Disabled</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>ARK.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Claude Reed</b>		14. MOTHER'S MAIDEN NAME <b>BESSIE (Gammon) Reed</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No None</b>		16. SOCIAL SECURITY NO. <b>545-40-0343</b>	
17. INFORMANT <b>BCH RECORDS: 4940 Eastern Avenue Baltimore, Maryland 21224</b>		ADDRESS	
18. CAUSE OF DEATH <b>Myocardial Infarction</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart attack, etc., it means the disease, injury or condition which caused death.) <b>ASCVD</b> DISEASES OR CONDITIONS WHICH CONTRIBUTE TO THE ABOVE CAUSE OF DEATH <b>38% Body Burns</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>6 days</b>	
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HOME</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>HOME 301 Pleasant Ridge Drive Owings Mills Md.</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>1 6 72 1:30</b>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>Fluid from lighter caught in fire</b>	
22. I certify that (this hospital) attended the deceased from <b>1-6 1972</b> to <b>1-12 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>1-12-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>FRANCISCO JOSE NEGRI, MD</b>		23D. ADDRESS <b>Baltimore City Hospitals</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/14/1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn - Balto. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>P. E. Fisher, MD</b>	
25C. FUNERAL DIRECTOR <b>7828 Liberty Road Loring, Byers Funeral Directors, PA 21133</b>		ADDRESS	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

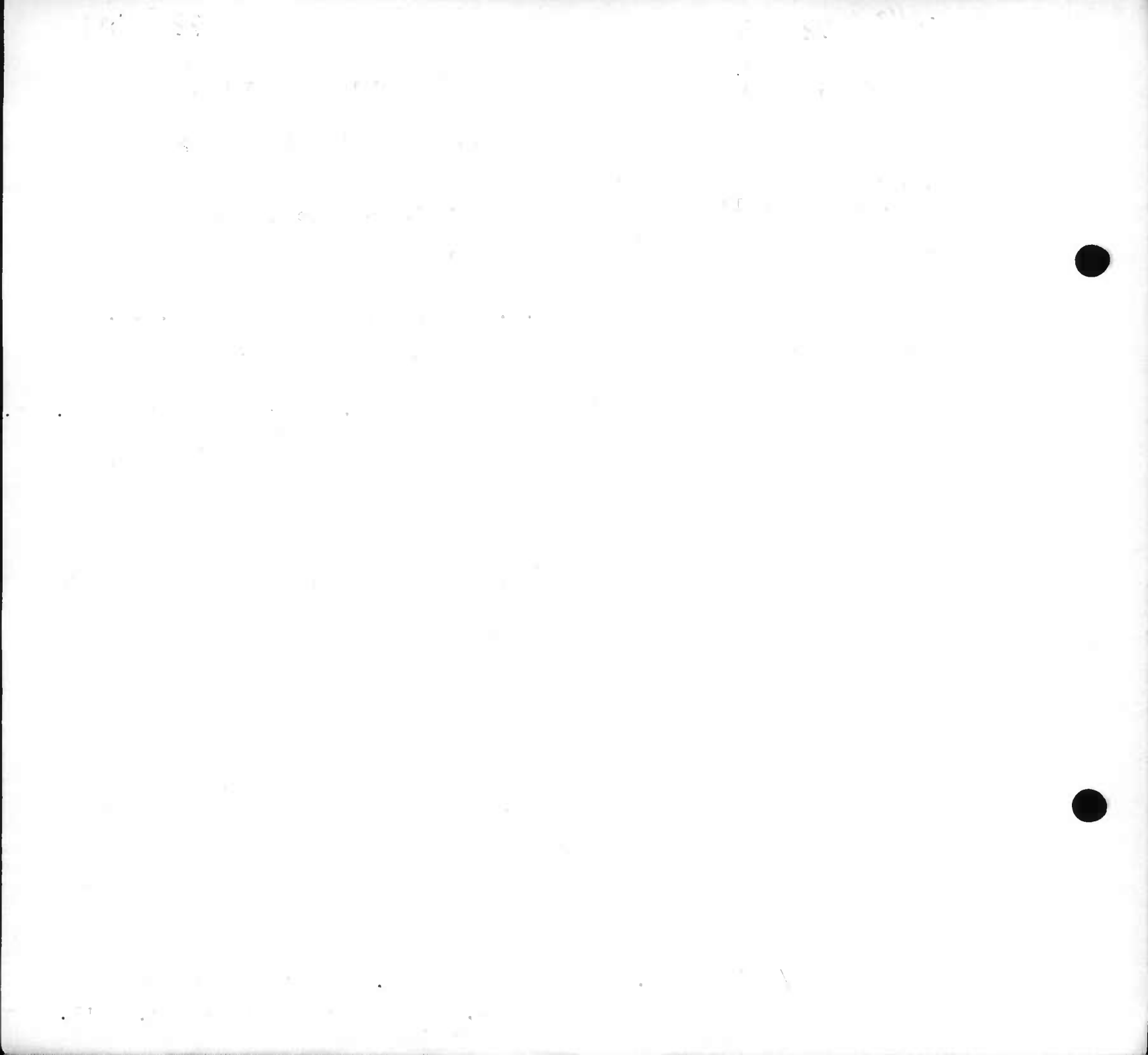
<p><b>B-152 72 00510</b></p> <p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 00510</b></p>	
<p>BIRTH NO.</p> <p>1. NAME OF DECEASED (Type or Print) <b>EVANS, LOIS</b></p>		<p>2. DATE AND HOUR OF DEATH <b>11/13/72 at 2:40 a.m.</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>46 Lutheran Hospital of Maryland</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>md-</b> B. COUNTY <b>2646</b></p> <p>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> <p>E. STREET AND NUMBER <b>1600 Charlotte Ave - 21224</b></p>	
<p>5. SEX <b>Female</b></p>	<p>6. RACE <b>White</b></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>8-31-16</b></p>
<p>9. AGE (In years last birthday) <b>55</b></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>	<p>11. BIRTHPLACE (State or foreign country) <b>Cristfield, Md.</b></p>
<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>		<p>13. FATHER'S NAME <b>Noah S. Kelly</b></p>	
<p>14. MOTHER'S MAIDEN NAME <b>Minnie Mason</b></p>		<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>	
<p>16. SOCIAL SECURITY NO.</p>		<p>17. INFORMANT ADDRESS <b>Rev. John N. Evans Sr 1600 Charlotte Ave</b></p>	
<p>18. <b>1991 I</b> CAUSE OF DEATH <b>Terminal Carcinoma.</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, osihenia, etc. It means the disease, injury or complication which caused death.)</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p> <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>			
<p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.)</p>	
<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>11/13/1972</b> to <b>11/13/1972</b> that (I) (we) last saw the deceased alive on <b>11/13/1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Angana Doshi MD</b></p>		<p>23B. DATE SIGNED</p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>ANGANA DOSHI MD</b></p>		<p>23D. ADDRESS</p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify)</p>		<p>24B. DATE <b>1/16/1972</b></p>	
<p>24C. NAME OF CEMETERY or CREMATORY <b>Sunny Ridge Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Cristfield, Maryland</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>P. E. Feltz, M.D.</b></p>	
<p>25C. FUNERAL DIRECTOR ADDRESS <b>G. Truman Schwab 3512 Frederick Ave.</b></p>		<p>25D. NAME OF REGISTRAR <b>P. E. Feltz, M.D.</b></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BIRTH NO.</b></p> <p style="font-size: 24pt;">72 00511</p>		<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p><b>REG. NO.</b></p> <p style="font-size: 24pt;">72 00511</p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print)</p> <p>Stever, Norman F</p>			<p><b>2. DATE AND HOUR OF DEATH</b></p> <p>1/12/72 11:15p.m.</p>		
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p>St. Agnes Hospital Emergency Room 900 S. Caton Ave. 21229</p>			<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution residence before admission)</p> <p>A. STATE B. COUNTY</p> <p>Md. Baltimore</p>		
<p><b>5. SEX</b></p> <p>Male</p>			<p><b>6. RACE</b></p> <p>White</p>		
<p><b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>			<p><b>8. DATE OF BIRTH</b></p> <p>12/17/06</p>		
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)</p> <p>Claim Agent</p>			<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b></p> <p>Pennsylvania R.R.</p>		
<p><b>11. BIRTHPLACE</b> (State or foreign country)</p> <p>Pennsylvania</p>			<p><b>12. CITIZEN OF WHAT COUNTRY?</b></p> <p>U.S.A.</p>		
<p><b>13. FATHER'S NAME</b></p> <p>John Stever</p>			<p><b>14. MOTHER'S MAIDEN NAME</b></p> <p>Angeline Fullmer</p>		
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p> <p>No</p>			<p><b>16. SOCIAL SECURITY NO.</b></p> <p>716-16-6148</p>		
<p><b>17. INFORMANT</b></p> <p>Mrs Clela E. Stever</p>			<p><b>ADDRESS</b></p> <p>2215 Old Fred. Rd.</p>		
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p>ACUTE MYOCARDIAL INFARCTION</p>			<p><b>CAUSE OF DEATH</b></p> <p>ACUTE MYOCARDIAL INFARCTION</p>		
<p><b>19. ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>			<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p> <p>1 hr.</p>		
<p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p> <p>None</p>			<p><b>ADENOCARCINOMA PROSTATE</b></p>		
<p><b>19A. DATE OF OPERATION</b></p> <p>0</p>			<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		
<p><b>20A. AUTOPSY?</b> (Yes or No)</p> <p>No</p>			<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>		
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p>			<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>			<p><b>21D. TIME OF INJURY</b> (Month (Day) (Year) (Hour) (Approx.))</p>		
<p><b>21E. INJURY OCCURRED</b></p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>			<p><b>21F. HOW DID INJURY OCCUR?</b></p>		
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>October 1971</u> <b>to</b> <u>1/12/72</u> <b>19</b></p> <p><b>that (I) (we) last saw the deceased alive on</b> <u>1/12/72</u> <b>19</b> <b>and that (in my) (our) opinion death occurred on the date</b></p> <p><b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>					
<p><b>23A. SIGNATURE</b></p> <p>B. Martin Middleton M.D.</p>			<p><b>23B. DATE SIGNED</b></p> <p>1/12/72</p>		
<p><b>23C. PHYSICIAN'S NAME</b> (Type)</p> <p>B. Martin Middleton M.D.</p>			<p><b>23D. ADDRESS</b></p> <p>3300 W. Ikeno Ave Balto 29, Md</p>		
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)</p> <p>Burial</p>		<p><b>24B. DATE</b></p> <p>1/15/1972</p>		<p><b>24C. NAME of CEMETERY or CREMATORY</b></p> <p>St. Peters Lutheran Cem.</p>	
<p><b>24D. LOCATION</b> (City, town, or county) (State)</p> <p>Hilltown, Pennsylvania</p>		<p><b>25A. DATE REC'D BY HEALTH DEPT.</b></p> <p>JAN 18 1972</p>			
<p><b>25B. NAME OF REGISTRAR</b></p> <p>John E. Taylor, M.D.</p>		<p><b>25C. FUNERAL DIRECTOR</b></p> <p>Truman Schwab 5151 Balto. Nat'l Pike</p>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-200 72 00512		BALTIMORE CITY HEALTH DEPARTMENT		72 00512	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Blanche J. Marks</i>		2. DATE AND HOUR OF DEATH <i>1/12/72 5:00 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD.</i> B. COUNTY <i>BALTO.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>PROVIDENT Hospital</i>		C. CITY OR TOWN <i>Balto.</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <i>3634 Forest Hill Rd.</i>			
5. SEX <i>F</i>	6. RACE <i>N</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3/21/10</i>	9. AGE (In years last birthday) <i>61</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Nurse</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Hospital</i>		11. BIRTHPLACE (State or foreign country) <i>Ind.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
13. FATHER'S NAME <i>Nicholas Jones</i>		14. MOTHER'S MAIDEN NAME <i>Annie Berry</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>216-24-5009</i>		17. INFORMANT <i>Marion Jones</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <i>Adenocarcinoma of Colon</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>10-12 mo</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>1/5/72</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>May 1948</i> to <i>Jan 8 1972</i> , that (I) (we) last saw the deceased alive on <i>Jan 8 1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>H. Garland Chissell MD</i>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>Jan 13, 1972</i>	
23C. PHYSICIAN'S NAME (Type) <i>H. Garland Chissell MD</i>		23D. ADDRESS <i>940 W. North Baltimore Md</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/18/72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Arbuthnot Park</i>	
24D. LOCATION (City, town, or county) (State) <i>Balto. Ind.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1972</i>		25B. NAME OF REGISTRAR <i>John E. Jones, M.D.</i>		25C. FUNERAL DIRECTOR <i>Chissell Funeral Home</i>	
				ADDRESS <i>1201 McE...</i>	

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

10/10/19

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-600 72 00513		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00513	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Mary E Orye</i>		2. DATE AND HOUR OF DEATH <i>11/13/72</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>2002</i>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <i>00</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>2530 W. Fayette St</i>		C. CITY OR TOWN <i>Baltimore</i>	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <i>Female</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <i>August 8, 1988</i>		9. AGE (In years last birthday) <i>83</i>		If Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Domestic</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>House</i>		11. BIRTHPLACE (State or foreign country) <i>Maryland</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>Unknown</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-38-4384</i>		17. INFORMANT <i>Earl Orye 1004 West Blvd, North Columbia Mo.</i>	
18. <i>4-10-19 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Cerebral Occlusion 2 weeks</i> (B) <i>Arterial Sclerosis</i> DUE TO, OR AS A CONSEQUENCE OF: <i>Senility</i> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Charles A. Cahn</i>		23B. DATE SIGNED <i>1/14/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Charles A. Cahn</i>	
23D. ADDRESS <i>2145 W. Baltimore, Md</i>		24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>11/17/72</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>St. Marks Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Petersville, Frederick, Maryland</i>		25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1972</i>	
25B. NAME OF REGISTRAR <i>James E. Taylor, Jr.</i>		25C. FUNERAL DIRECTOR <i>Amberose Inc 1328 Sulphur Sp. Rd.</i>		ADDRESS	

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55

5/10/55



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT									
CERTIFICATE OF DEATH					REG. NO. <span style="float: right;">72 00514</span>				
BIRTH NO. <span style="float: right;">72 00514</span>					1. NAME OF DECEASED (Type or Print) <b>HUBER, ERNEST THEODORE</b>				
2. DATE AND HOUR OF DEATH <b>01/15/72 6:40AM</b>					3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>A A</b>					FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 ST AGNES HOSPITAL</b>				
C. CITY OR TOWN <b>BALTIMORE</b>					D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
E. STREET AND NUMBER <b>177 PARK ROAD PASADENA MD 21122</b>									
5. SEX <b>MALE</b>		6. RACE <b>CAUCASIAN</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>07/01/09</b>		9. AGE (in years last birthday) <b>62</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SALES ENGINEER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Self-Employed</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>WILLIAM HUBER</b>					14. MOTHER'S MAIDEN NAME <b>MARIA SCHMIDT</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>218 01 9606</b>		17. INFORMANT ADDRESS <b>6 ST AGNES HOSPITAL BALTO MD 21229</b>					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary edema</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs</b>				
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>myocardial infarction</b> <b>interseptal recent</b>				
					(B) DUE TO, OR AS A CONSEQUENCE OF:				
					(C)				
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>metastatic adenocarcinoma of colon</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 yr</b>				
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (X) (this hospital) attended the deceased from <b>01/04/72</b> 19 to <b>01/15/72</b> 19 that (X) (we) last saw the deceased alive on <b>01/015/72</b> 19 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (Y) (We) (did) (d/d'not) view the body after death.									
23A. SIGNATURE <b>JOSE APTER M.D.</b>					23B. DATE SIGNED <b>01 15 72</b>			23C. PHYSICIAN'S NAME (Type) <b>JOSE APTER M.D.</b>	
23D. ADDRESS <b>CATON &amp; WILKENS AVES. BALTO., MD. 21229</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/19/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md. Anne Arundel</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>P. S. S. S. S.</b>		25C. FUNERAL DIRECTOR <b>Pasadena, Md. ADDRESS</b> <b>McCurly Funeral Home Mountain &amp; Tick Neck Rd</b>					

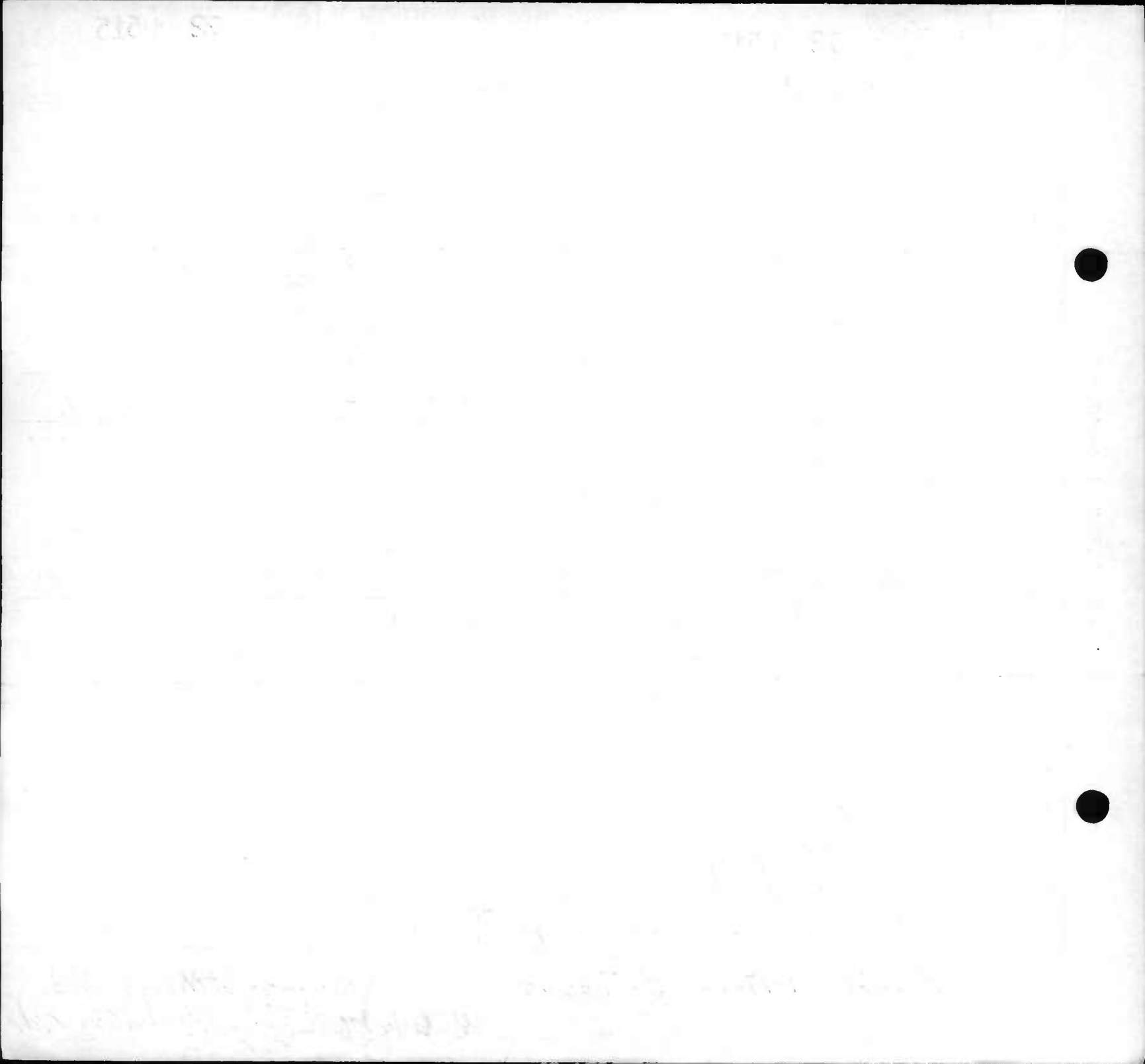
1100 36

1100 36

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

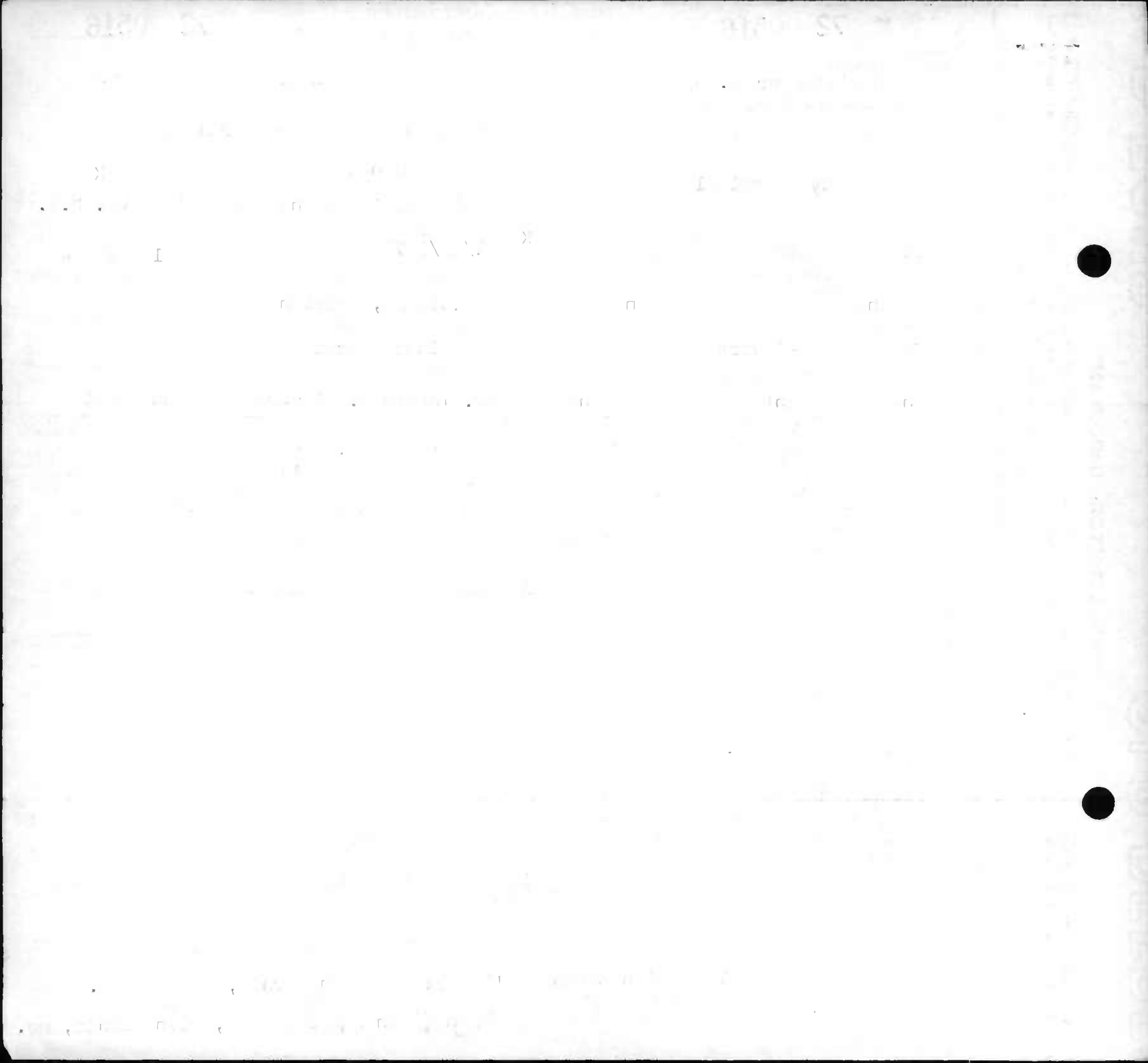
S-530 72 00515		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00515	
BIRTH NO. 72 00515				1. NAME OF DECEASED (Type or Print) SMITH, HENRY NORMAN			
2. DATE AND HOUR OF DEATH 1-14-1972 7:25 A.M.				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION Memorial Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY Maryland ST. MARY'S 6800			
C. CITY OR TOWN BAITIMORE				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER DRAYDEN MARYLAND 20630							
5. SEX M		6. RACE N		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 4-12-1909	
9. AGE (In years last birthday) 65		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JONES J. SMITH				14. MOTHER'S MAIDEN NAME AMANDA WYATTS			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mattie Watts Drayden, Md.	
18. 4-12-31-2309 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CARDIAC ARREST			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF: CONGESTIVE HEART FAILURE			
				(C) ARTERIOSCLEROTIC HEART DISEASE			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Diabetes Mellitus							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, home, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-12-1972 to 1-14-1972 that (I) (we) last saw the deceased alive on 1-14-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE A. Battilana MD				23B. DATE SIGNED 1-14-1972			
23C. PHYSICIAN'S NAME (Type) C. Z. 105 A. Battilana MD				23D. ADDRESS UNION Memorial Hospital			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-17-72		24C. NAME OF CEMETERY or CREMATORY Bethesda		24D. LOCATION (City, town, or county) (State) Valley Lee St Mary's Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS W. C. Clark, Mattingly Leonardtown, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

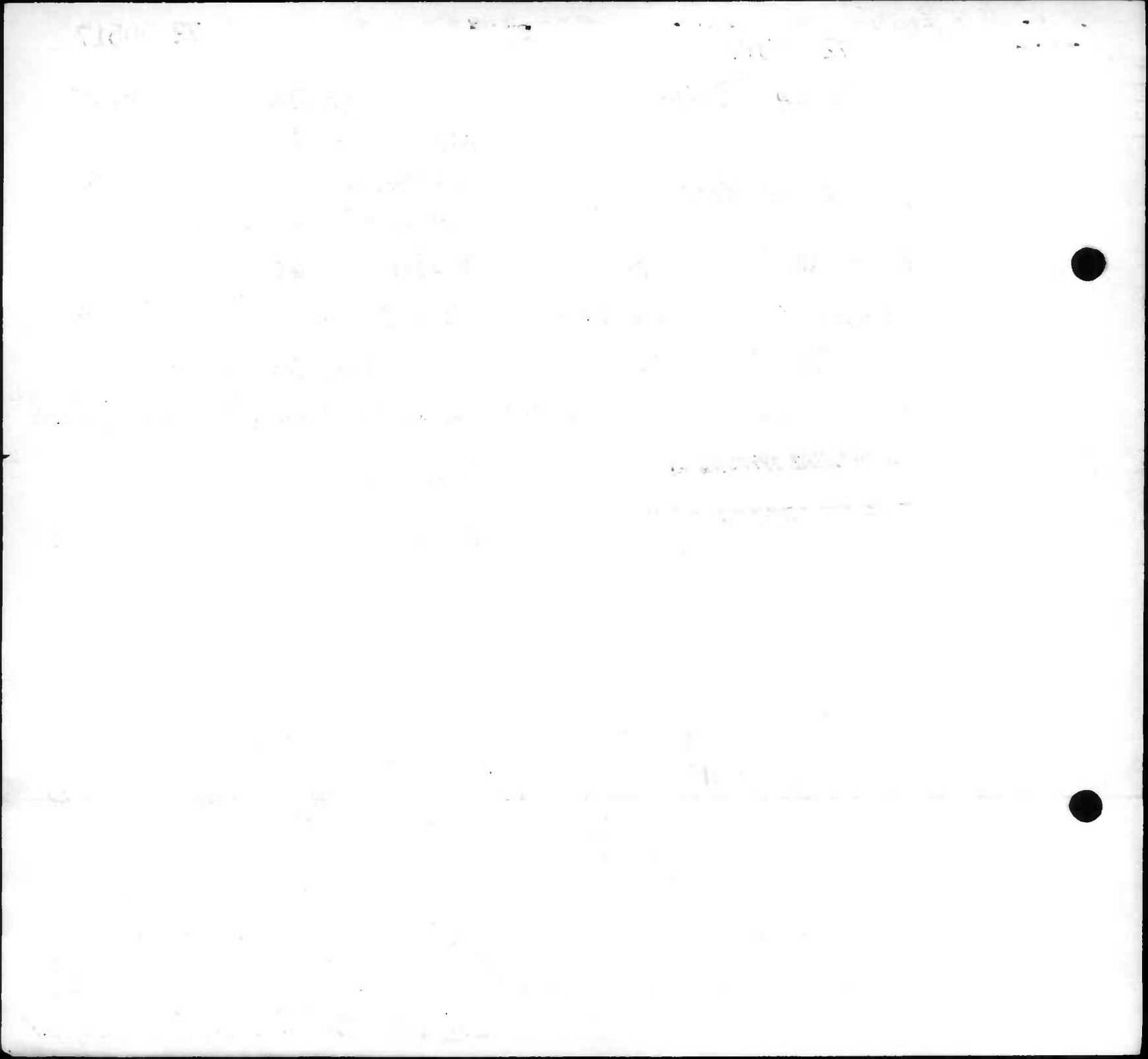
<div style="display: flex; justify-content: space-between;"> <span>8-416 72 00516</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>		REG. NO. <span style="font-size: 1.5em;">72 00516</span>	
BIRTH NO. <span style="font-size: 1.2em;">72-00591</span>		2. DATE AND HOUR OF DEATH <div style="display: flex; justify-content: space-between;"> <span>1-14-72</span> <span>3:30 P. M.</span> </div>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Christophor E. Silvers</span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">37 Mercy Hospital</span>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Anne Arundel</span>	
		C. CITY OR TOWN <span style="font-size: 1.2em;">Glen Burnie</span>	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER <span style="font-size: 1.2em;">612 Baltimore and Annapolis Blvd. N.E.</span>	
5. SEX <span style="font-size: 1.2em;">Male</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">1/13/1972</span>
		9. AGE (In years last birthday) <div style="display: flex; justify-content: space-between;"> <span>1</span> <span>3</span> <span>4</span> </div>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">None</span>
		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Baltimore, Maryland</span>	12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>
13. FATHER'S NAME <span style="font-size: 1.2em;">Thomas J Silvers</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Linda Reed</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">None</span>	16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">None</span>	17. INFORMANT <span style="font-size: 1.2em;">Mr. Thomas J. Silvers</span>	
		ADDRESS <span style="font-size: 1.2em;">Same as 4</span>	
18. CAUSE OF DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p style="text-align: center;"><b>I</b></p> <p style="text-align: center;">DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;"><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 45%;"> <p style="text-align: center;">Cardio-respiratory arrest (clinical)</p> <p style="text-align: center;">Bilateral diffuse hypoaeration of lungs</p> </div> </div>			
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <p style="text-align: center;"><b>II</b></p> <p style="text-align: center;">OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p> </div> <div style="width: 45%;"></div> </div>			
19A. DATE OF OPERATION <span style="font-size: 1.2em;">1</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">YES</span>	
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="font-size: 1.2em;">(If in Baltimore City, give exact location)</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (mostly medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">Glen Haven Mem'l Park</span>	
21C. WHERE DID INJURY OCCUR? <span style="font-size: 1.2em;">Glen Burnie, AA Md.</span>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <span style="font-size: 1.2em;">1/14 1972</span>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
		21F. HOW DID INJURY OCCUR? <span style="font-size: 1.2em;">Singletoh Funeral Home, Glen Burnie, Md.</span>	
22. I certify that (1) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1/13</span> 19 <span style="font-size: 1.2em;">71</span> to <span style="font-size: 1.2em;">1/14</span> 19 <span style="font-size: 1.2em;">71</span> and that (2) (our) lost saw the deceased alive on <span style="font-size: 1.2em;">1/14</span> 19 <span style="font-size: 1.2em;">71</span> and that (3) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.2em;">E. Utzurn</span> M.D.		23B. DATE SIGNED <span style="font-size: 1.2em;">1/15/72</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">EUGENIA B. UTZURN</span>		23D. ADDRESS <span style="font-size: 1.2em;">Singletoh Funeral Home, Glen Burnie, Md.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>	24B. DATE <span style="font-size: 1.2em;">1/17/72</span>	24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Glen Haven Mem'l Park</span>	24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Glen Burnie, AA Md.</span>
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">JAN 18 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">E. Utzurn</span>	
		25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Singletoh Funeral Home, Glen Burnie, Md.</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

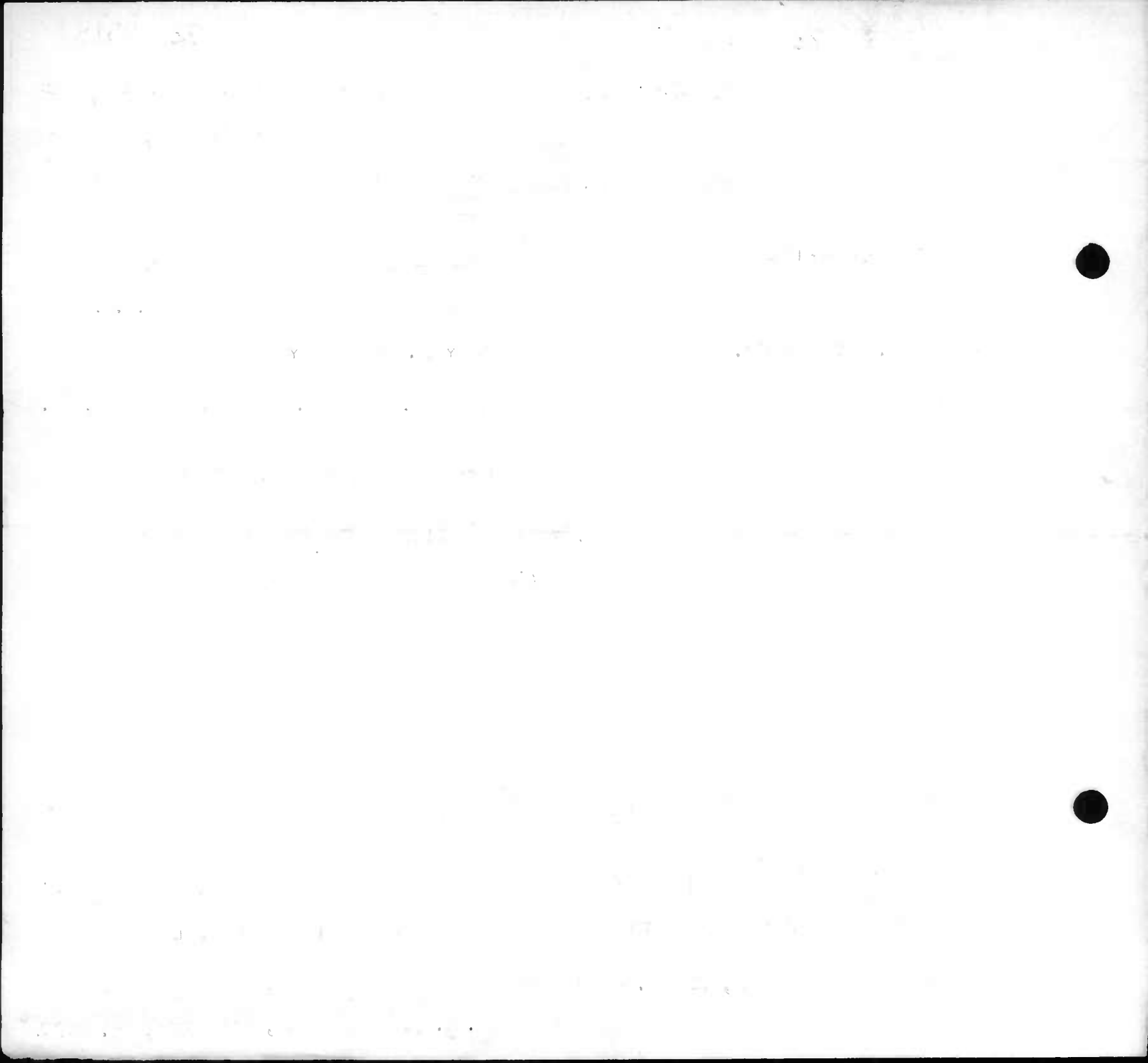
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 00517</b>	
D-140		<b>72 00517</b>		<b>CERTIFICATE OF DEATH</b>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>MAR GOLDA DORVAL</b>		2. DATE AND HOUR OF DEATH <b>1/13/72 0135 M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIV OF MD Hosp</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>AA</b> C. CITY OR TOWN <b>GAMBRILL</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>Box 2 - Tulip Hill</b>			
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/2/19</b>	9. AGE (In years last birthday) <b>60</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Odenton, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>JOHN Hood</b>		14. MOTHER'S MAIDEN NAME <b>HATTIE Lowman</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220-16-4723</b>		17. INFORMANT <b>Thomas R. Duvall (son)</b> ADDRESS <b>1763 Circle Drive Severn, Md.</b>	
18. CAUSE OF DEATH <b>CERTIFICATE OF CONDITION DIRECTLY APPROVED BY</b> (This does not mean the mode of death, e.g., heart failure, etc., but the disease, injury, or condition which caused the death.) <b>ANTICIPATED CAUSES</b> DISEASES OR CONDITIONS, giving rise to the above cause (A) existing the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIO VASC DISEASE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 HRS</b>	
		(B) <b>BURNS</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>4 DAYS</b>	
		(C)			
19A. DATE OF OPERATION <b>1/8/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <b>NONE</b>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>GAMBRILL 52-00</b>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>1 8 72 2030</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <b>FIRE AT HOME</b>		22. I certify that (1) (this hospital) attended the deceased from <b>1/8</b> 19 <b>72</b> to <b>1/13</b> 19 <b>72</b> , that (1) (we) last saw the deceased alive on <b>1/13</b> 19 <b>72</b> and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Kristin Stueber MD</b>		23B. DATE SIGNED <b>1/13/72</b>		23C. PHYSICIAN'S NAME (Type) <b>KRISTIN STUEBER MD</b>	
23D. ADDRESS <b>UNIV OF MD Hosp</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1/18/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Fort Lincoln Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Blacksburg Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>E. Taylor, MD</b>		25C. FUNERAL DIRECTOR <b>Sergeant Funeral Home, Cedar Ridge, Md.</b>	





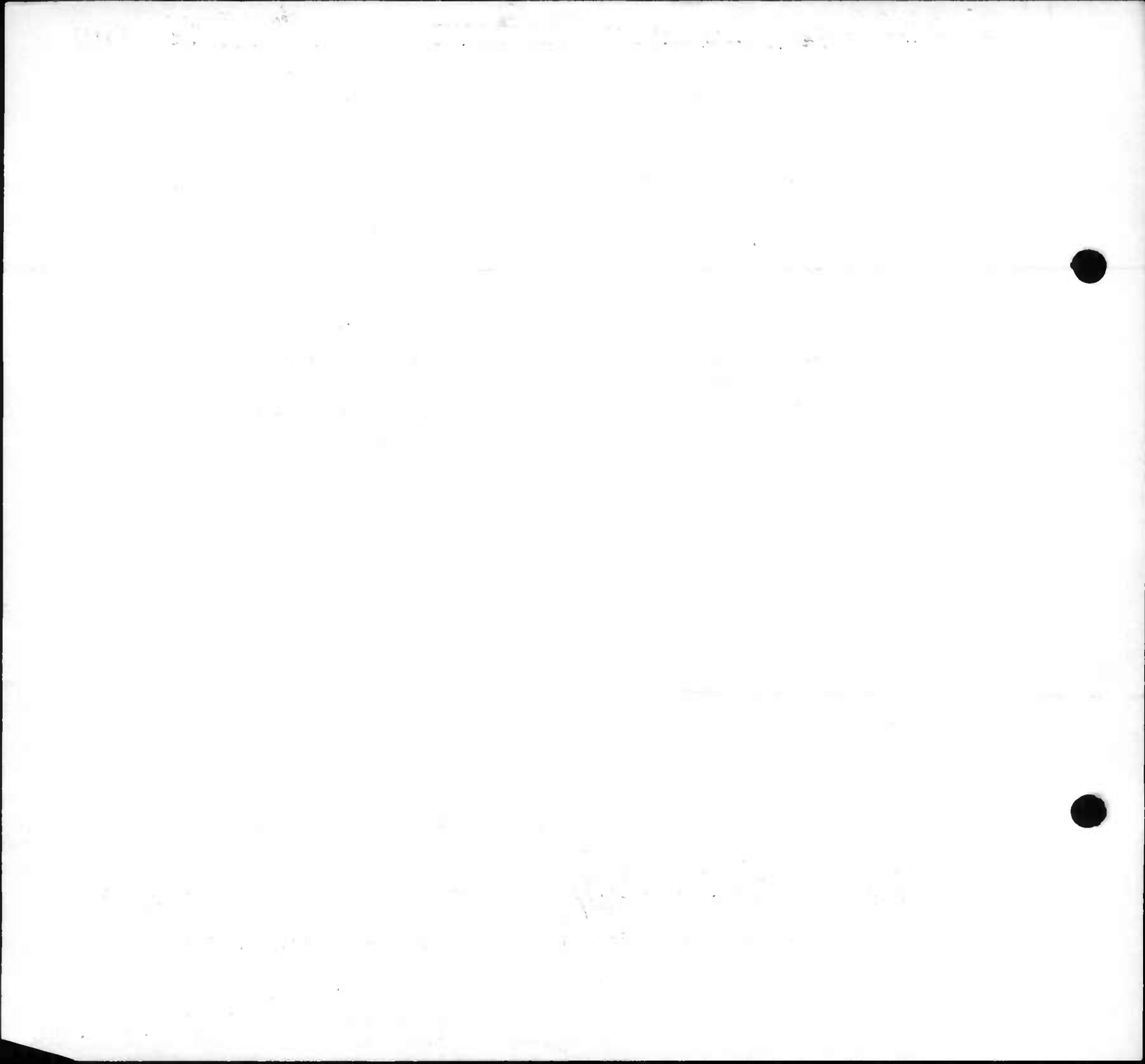
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00518</span>	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
Dr. Frederick, M.D. McCUE, Kathleen		JANUARY 13 1972 11 <sup>15</sup> P.M.		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
33 THE JOHNS HOPKINS HOSPITAL		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		5. CITY OR TOWN	
		A. STATE MARYLAND B. COUNTY FREDERICK		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER RT 7			
6. SEX	7. RACE	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	9. DATE OF BIRTH	10. AGE (In years last birthday)	11. If Under 1 Yr. Months: Days: Hours: Min.
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-12-72	1-12-72	1-12-72
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
				Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
JAMES J. McCUE JR.		MARY D. ROSANSKY		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		None		James J. McCue Jr. Route 7, Frederick, Md.	
18. CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
ANTECEDENT CAUSES					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.					
(A) IMMEDIATE CAUSE: CARDIAC ARRHYTHMIA and asystole					
DUE TO, OR AS A CONSEQUENCE OF:					
(B) Congenital Cardiac Malformations - severe					
DUE TO, OR AS A CONSEQUENCE OF:					
(C) Multiple congenital anomalies					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from JANUARY 12 1972 to JANUARY 13 1972 that (I) (we) last saw the deceased alive on JAN 13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Stan Coopersmith M.D.		13 January 1972		STAN COOPERSMITH	
23D. ADDRESS		24. BURIAL CREMATION, REMOVAL (Specify)			
THE JOHNS HOPKINS HOSPITAL		Burial			
		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
		Jan 15, 72		St. John's Cemetery	
		24D. LOCATION		24E. DATE REC'D BY HEALTH DEPT.	
		Frederick, Maryland 21701		JAN 18 1972	
		25. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
		M. B. Echison, M.D.		M. B. Echison & Son, 406 East Church Street, Frederick, Md. 21701	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

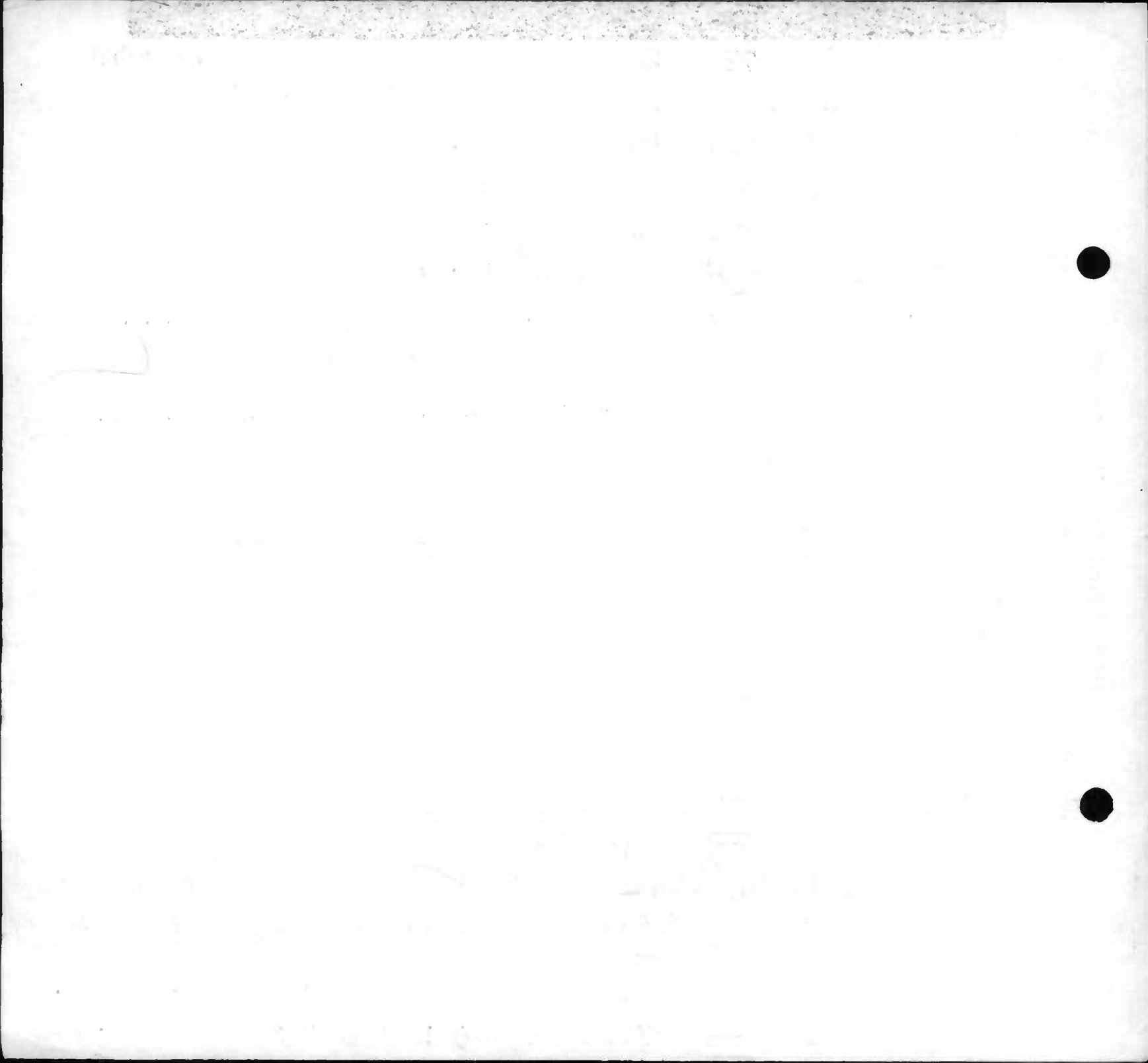
B-460 72 00519		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00519	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Frances M. Blair		2. DATE AND HOUR OF DEATH Jan. 14, 1972 11:00 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 5651 Govane Avenue Baltimore, Md. 21212		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland 21212 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 5651 Govane Avenue		2778	
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8/21/1882	9. AGE (In years last birthday) 89	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Seamstress		10B. KIND OF BUSINESS OR INDUSTRY Sewing		11. BIRTHPLACE (State or foreign country) Baltimore, Md.	
13. FATHER'S NAME Clarence Johnson		14. MOTHER'S MAIDEN NAME Josephine Woodfield		12. CITIZEN OF WHAT COUNTRY? USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 216-28-5156		17. INFORMANT Edna M. Johnson (Sister) Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Carcinoma of Right Breast (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastasis 19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 10/16 1970 to 11/14/72 1972 that (I) (we) last saw the deceased alive on 11/6 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Thomas L. Worsley		23B. DATE SIGNED 11/15/72		23C. PHYSICIAN'S NAME (Type) Dr. Thomas L. Worsley	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/72		24C. NAME OF CEMETERY or CREMATORY New Cathedral Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1972		25B. NAME OF REGISTRAR P. E. J. J. J.		25C. FUNERAL DIRECTOR Eugenia K. Seitz ADDRESS Seitz Funeral Home 5209 York Rd. Balto. Md.	
24D. LOCATION (City, town, or county) (State) Baltimore, Maryland					



# FUNERAL DIRECTOR: IMPORTANT

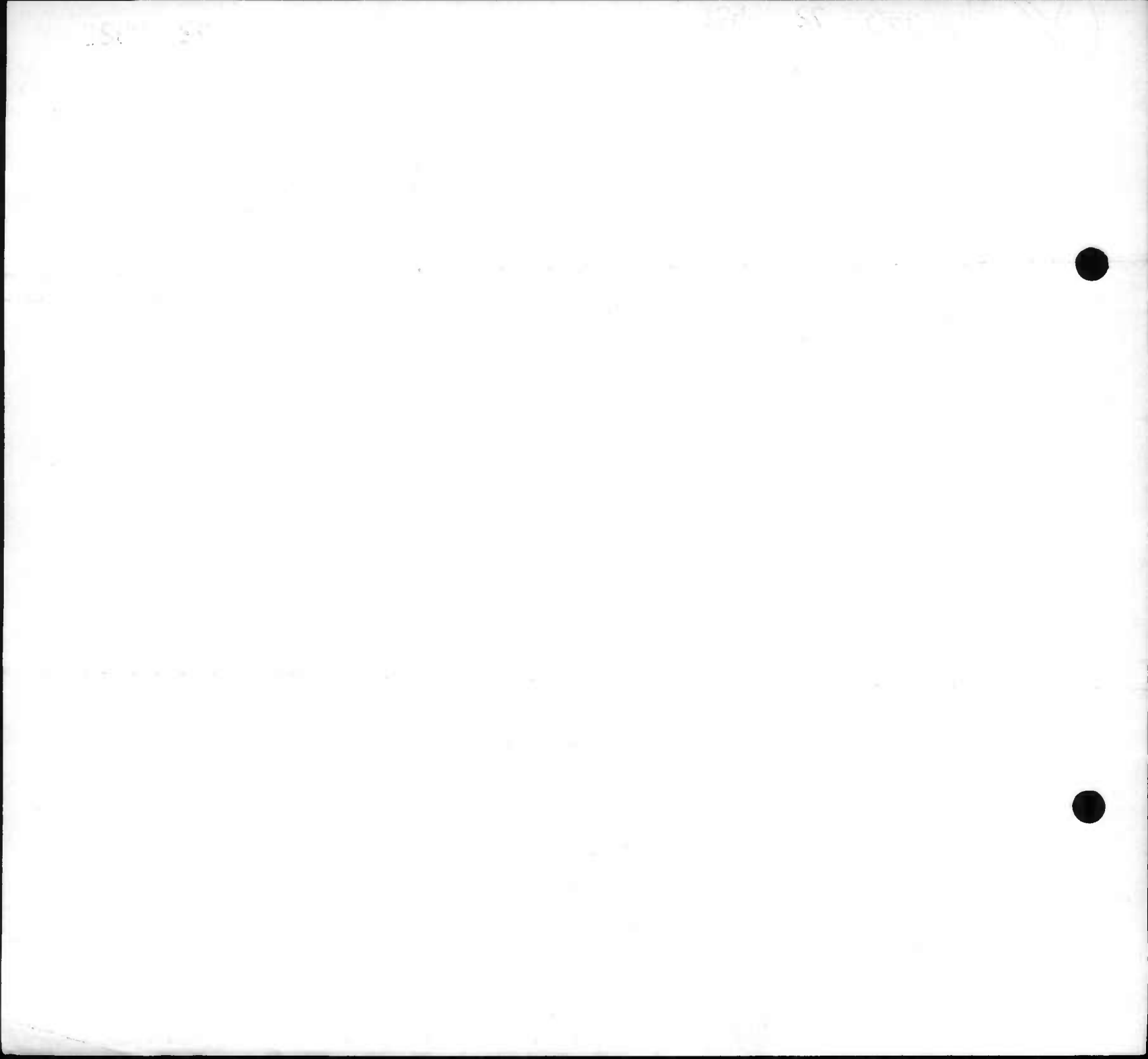
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO.	
BIRTH NO. <b>P-300 72 00520</b>		<b>CERTIFICATE OF DEATH</b>		72 00520	
1. NAME OF DECEASED (Type or Print) <b>Alfred Louis Ritt</b>		2. DATE AND HOUR OF DEATH <b>January 12, 1972</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 Mercy Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Kingsville</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>7224 Sunshine Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 2, 1906</b>	9. AGE (In years last birthday) <b>65</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Clerk</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Electric Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Germany</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Joseph Ritt</b>			
14. MOTHER'S MAIDEN NAME <b>Madgelina Lenhardt</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>212-05-4970A</b>		17. INFORMANT <b>Mary E. Ritt 7224 Sunshine Ave. Kingsville</b>			
18. <b>4 10 71</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Myocardial Infarction</b>		19. CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary Insufficiency</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>II</b>		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
22. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-3</b> <b>1960</b> to <b>12-28</b> <b>1971</b> that (I) (we) last saw the deceased alive on <b>12-28</b> <b>1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>1-14-72</b>		23C. PHYSICIAN'S NAME (Type) <b>S. RUSSO</b>	
23D. ADDRESS <b>5017 Norford Rd Baltimore Md</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1/15/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens Of Faith Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Overlea Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>E. F. Lassahn F. H. 11750 Belair Rd. 21087</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 00521	
CERTIFICATE OF DEATH		REG. NO. 72 00521	
BIRTH NO. 1-355		M. 72 00521	
1. NAME OF DECEASED (Type or Print) <b>HARRY C. LOTMAN</b>		2. DATE AND HOUR OF DEATH <b>1-13-72</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>2402</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>43 S.B. G.H.</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>530 E. CLEMENT ST</b>	
5. SEX <b>M.</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-25-13</b>
9. AGE (In years last birthday) <b>58</b>		10. UNDER 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mech Rep.</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>B.G. &amp; E. Co</b>	
11. BIRTHPLACE (State or foreign country) <b>MD.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>HARRY I.</b>		14. MOTHER'S MAIDEN NAME <b>FRANCES E. Shields</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Family - Same</b>		ADDRESS	
18. <b>410.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Coronary Occlusion</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Coronary Heart Disease</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>About 3 years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>October 1968</b> to <b>1/13 1972</b> that (I) (we) last saw the deceased alive on <b>10/25 1971</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Harry Deibel M.D.</b>		23B. DATE SIGNED <b>1/14/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. HARRY DEIBEL</b>		23D. ADDRESS <b>1226 Hanover St Baltimore Md</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/17/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Lot Oliver</b>		24D. LOCATION (City, town, or county) (State) <b>Ford Springs Pa</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>W. E. C. - 130 E. Fort St</b>		ADDRESS	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H400 72 00522		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 72 00522	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>Lillian M. Hall</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		2. DATE AND HOUR OF DEATH <i>1-12-72</i>   <i>9:30 p. M.</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>H. L. LUTHERAN</i>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Md</i> B. COUNTY <i>Balto.</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <i>BALTO</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i> 6. RACE <i>W</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <i>6023 - Gwynn, Oak Ave</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>home</i>		8. DATE OF BIRTH <i>12-16-02</i>	
13. FATHER'S NAME <i>Bryant Baaby</i>		14. MOTHER'S MAIDEN NAME <i>Mittie S. Bell</i>		9. AGE (In years last birthday) <i>69</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>216 10 85280</i>		11. BIRTHPLACE (State or foreign country) <i>VA</i>	
18. <i>519.1 I</i> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>Acute Pulmonary Oedema</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		17. INFORMANT ADDRESS <i>Clarence E. Hall Jr 2413 Burch Dr. 21207</i>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 Month (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/12/1972</i> to <i>1/12/1972</i> that (I) (we) last saw the deceased alive on <i>1/12/1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Anyana Dosh</i>		23B. DATE SIGNED <i>1/12/72</i>		23C. PHYSICIAN'S NAME (Type) <i>ANDANA DOSH</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>burial</i>		24B. DATE <i>1-15-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Parkwood Cem</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1972</i>		25B. NAME OF REGISTRAR <i>W. E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <i>Windsor Mill</i>	
25D. ADDRESS <i>6411 Gwynn Oak Ave</i>		25E. ADDRESS <i>6411 Gwynn Oak Ave</i>		25F. ADDRESS <i>6411 Gwynn Oak Ave</i>	

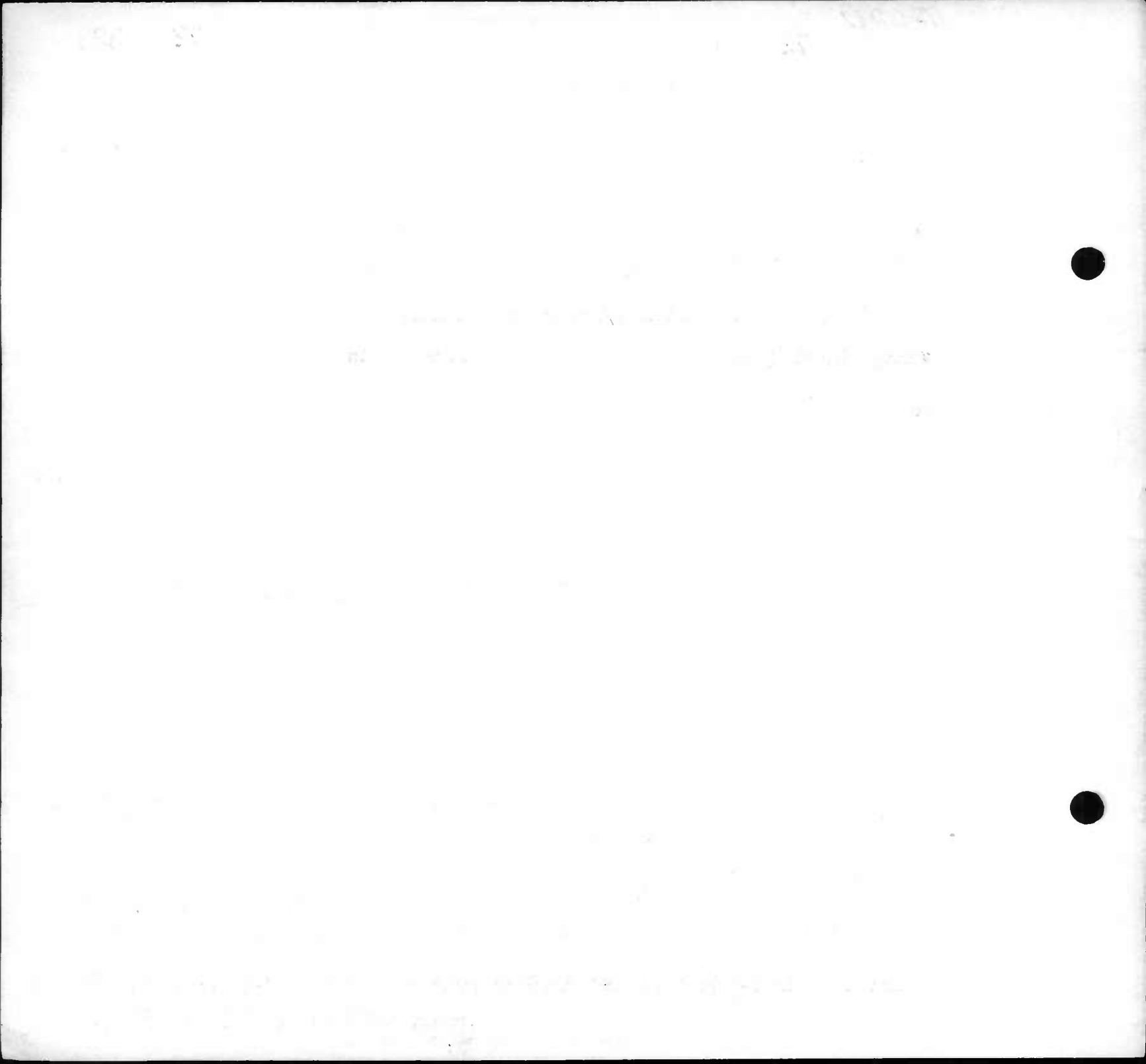
SS-01 28

100-35



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1		M-620		72 00523		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00523	
1. NAME OF DECEASED (Type or Print) <b>EARL ALBERT MYERS</b>						2. DATE AND HOUR OF DEATH <b>JANUARY 11, 1972 7:41 P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>MARYLAND GENERAL Hospital</b>						4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1205</b> C. CITY OR TOWN, <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1809 ST. PAUL ST.</b>					
5. SEX <b>MALE</b>		6. RACE <b>CAUCASIAN</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/14/06</b>		9. AGE (In years last birthday) <b>65</b>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GOOD HUMAN EMPLOYEE</b>						10B. KIND OF BUSINESS OR INDUSTRY <b>Salesman/Ice Cream</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Murray Albert Myers</b>						14. MOTHER'S MAIDEN NAME <b>Martha Wantz</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-10-8272</b>		17. INFORMANT ADDRESS <b>EMERGENCY ROOM CHART</b>					
18. <b>410.9 I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b> 20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>ONE HOUR</b>					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>INJURY OCCUR?</b> (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>JAN. 11 (7:15 PM) 1972</b> to <b>JAN. 11 (7:41 PM) 1972</b> that (I) (we) lost saw the deceased alive on <b>JAN. 11</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Richard H. Balcer M.D.</b>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>			23B. DATE SIGNED <b>1/11/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>RICHARD H. BALCER M.D.</b>						23D. ADDRESS <b>MARYLAND GENERAL Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>14 Feb 72</b>		24C. NAME of CEMETERY or CREMATORY <b>Moorehead Memorial Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>Union Mills, Carroll Co Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>				25B. NAME OF REGISTRAR <b>Robert E. Barber, M.D.</b>				25C. FUNERAL DIRECTOR ADDRESS <b>Burgess Funeral Home Baltimore Maryland</b>			



E-363

## BALTIMORE CITY HEALTH DEPARTMENT

72 00524

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00524

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES MICHAELS EDWARDS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 12, 1972</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 12, 1972</b>		4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 UNION MEMORIAL HOSPITAL</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1306</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>Jan 12 1955</b>		10. AGE (In years last birthday) <b>17</b> <del>16</del>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>James D. Edwards</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Plastics Mgr</b>		15. MOTHER'S MAIDEN NAME <b>Thelma Harris</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>219 66 8491</b>	
18. INFORMANT <b>Thelma Edwards</b>		ADDRESS <b>3529 Hickory Avenue</b>		19. <b>304.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Narcotics Addiction</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>15 Feb 72</b>		24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>		25A. DATE REC'D BY HEALTH DEPT.	
25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR <b>Burgess Funeral Home, Baltimore Maryland</b>		25D. ADDRESS <b>By: [Signature]</b>		25E. DATE SIGNED <b>1/12/72</b>			

19720000

15-00001

15-00001

15-00001

15-00001

15-00001

15-00001

15-00001

15-00001

15-00001

15-00001

15-00001

15-00001

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00525</u>
BIRTH NO. <u>72 00525</u> <u>MacKnew</u>		2. DATE AND HOUR OF DEATH <u>1/14/72 11:40 A.M.</u>		
1. NAME OF DECEASED (Type or Print) <u>LULU ELIZABETH MacKnew</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>B</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>+8 MARYLAND GEN HOSP</u>		C. CITY OR TOWN <u>BALTO</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MARYLAND GEN HOSP</u>		E. STREET AND NUMBER <u>328 W. 29th St</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6-17-86</u>	9. AGE (In years lost birthday) <u>85</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>
13. FATHER'S NAME <u>John Delker</u>		14. MOTHER'S MAIDEN NAME <u>-</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220 03 3706</u>		17. INFORMANT <u>Walter P MacKew</u> ADDRESS <u>328 W 29th Street</u>
18. <u>562.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Leading diverticulosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Aseptic total heart block</u>				
19A. DATE OF OPERATION <u>1/13/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>a diverticulosis</u>		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1/13</u> 19 <u>72</u> to <u>1/14/72</u> 19 <u>72</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>1/14</u> 19 <u>72</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.				
23A. SIGNATURE <u>Karl F. Meach, Jr. MD</u>		23B. DATE SIGNED <u>1/14/72</u>		23C. PHYSICIAN'S NAME (Type) <u>KARL F. MEACH, JR. MD</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>18 Feb 72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Lorraine Park Cemetery</u>
24D. LOCATION (City, town, or county) (State) <u>Woodlawn, Baltimore Co Maryland</u>		25A. DATE REC'D BY HEALTH DEPT <u>JAN 18 1972</u>		
25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD</u>		25C. FUNERAL DIRECTOR <u>Burgess Funeral Home, Baltimore Maryland</u>		

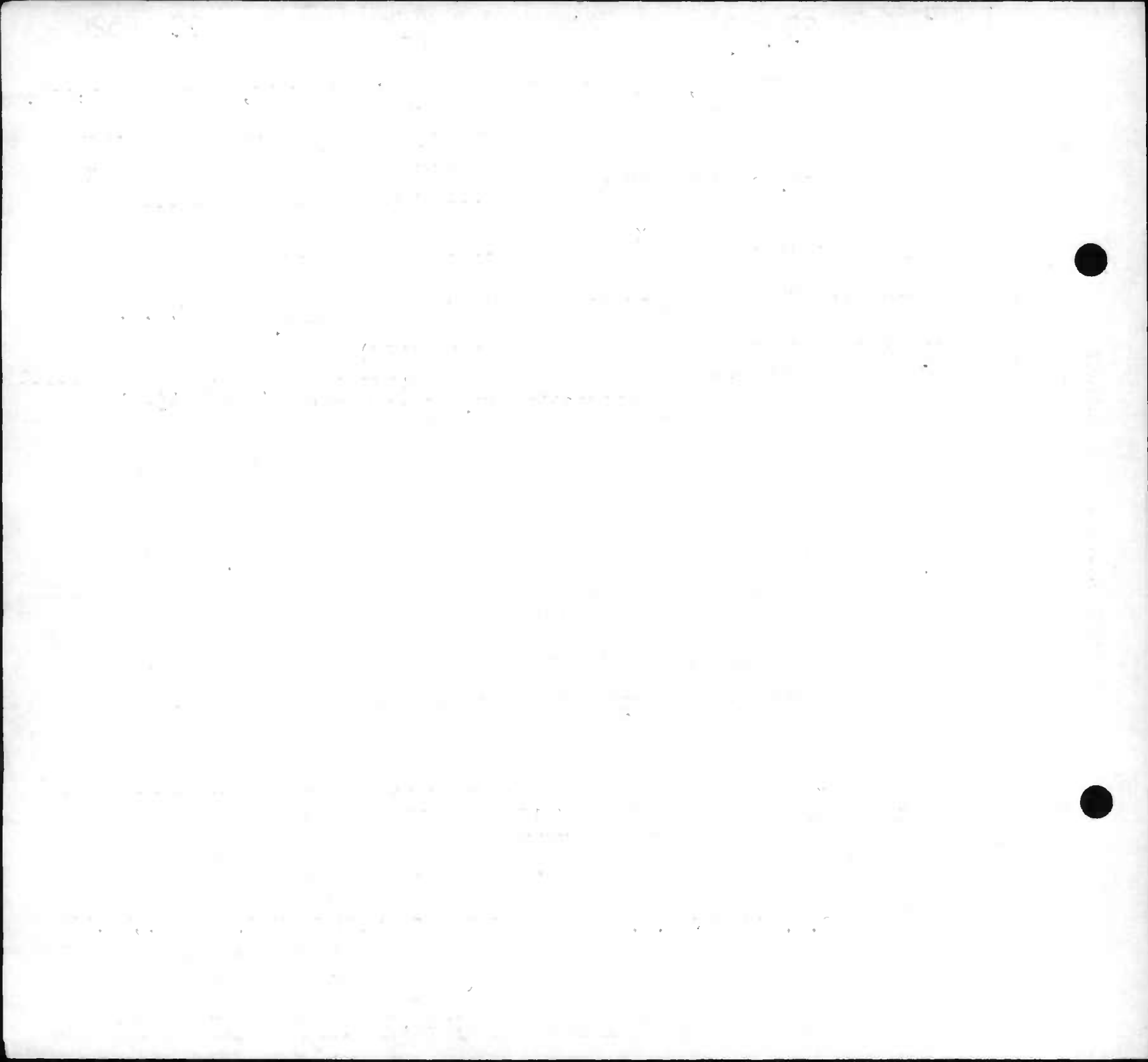




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
PATTERSON, WILBERT THOMAS		JANUARY 15, 1972 2:23PM	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE B. COUNTY	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		MARYLAND BALTIMORE 21207	
ST. AGNES HOSPITAL		C. CITY OR TOWN D. INSIDE CITY LIMITS?	
40		BALTIMORE YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER		1100 WESTBEND COURT APT 11C 5300	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
MALE	CAUCASIAN	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	01 09 96
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
ELECTRICIAN		ELECTRICAL	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
CHARLES PATTERSON		IDA (RILEY)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
NO		213033442	
17. INFORMANT		ADDRESS	
WILKENS AVES. BALTO., MD. 21229		ST. AGNES HOSPITAL RECORDS-CATON &	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		B. P. H.	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
II		(C)	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
NO		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (X) (this hospital) attended the deceased from JANUARY 14 19 72 to JANUARY 15 19 72 that (X) (we) lost saw the deceased alive on JANUARY 15 19 72 and that in (Xy) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXX) view the body after death.			
23A. SIGNATURE		23B. DATE SIGNED	
C.R. Chaney		1/15/72	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
C.R. CHANEY M.D.		CATON & WILKENS AVES. BALTO., MD. 21229	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
Burial		1/18/72	
24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Lorraine Park		Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
JAN 18 1972		Witzke, 1639 Edmondson Aven	
25C. FUNERAL DIRECTOR		ADDRESS	
		21228	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00527</span>	
72 00527				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Charlotte Berg</b>			2. DATE AND HOUR OF DEATH <b>1/14/72</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>90 General German Aged Peoples Home, 22 S. Athol Avenue</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md</b> B. COUNTY <b>2864</b>		
5. SEX <b>female</b>			6. RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>6/17/1892</b>			9. AGE (In years last birthday) <b>80 79</b>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <b>Switzerland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Late Adolph Emil Berg</b>			14. MOTHER'S MAIDEN NAME <b>Late Bertha Marie Buder</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <b>212-32-2413</b>		17. INFORMANT <b>22 S. Athol Avenue</b> <b>General German Aged Peoples Home</b> ADDRESS
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>(A) IMMEDIATE CAUSE <u>Lands Respiratory Failure</u></b> <b>(B) <u>Arterio-sclerotic Heart Disease</u></b> <b>(C) <u>chronic failure</u></b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 1969</b> to <b>14 Jan 1972</b> , that (I) (we) last saw the deceased alive on <b>14 Jan 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>William J. Bryson</b> 23C. PHYSICIAN'S NAME (Type) <b>Dr. Wm. J. Bryson</b>				23B. DATE SIGNED <b>14 Jan 72</b>	
23D. ADDRESS <b>Westview Mall</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/18/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Western Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>Witzke, 1630 Edmondson Ave., 21228</b>	

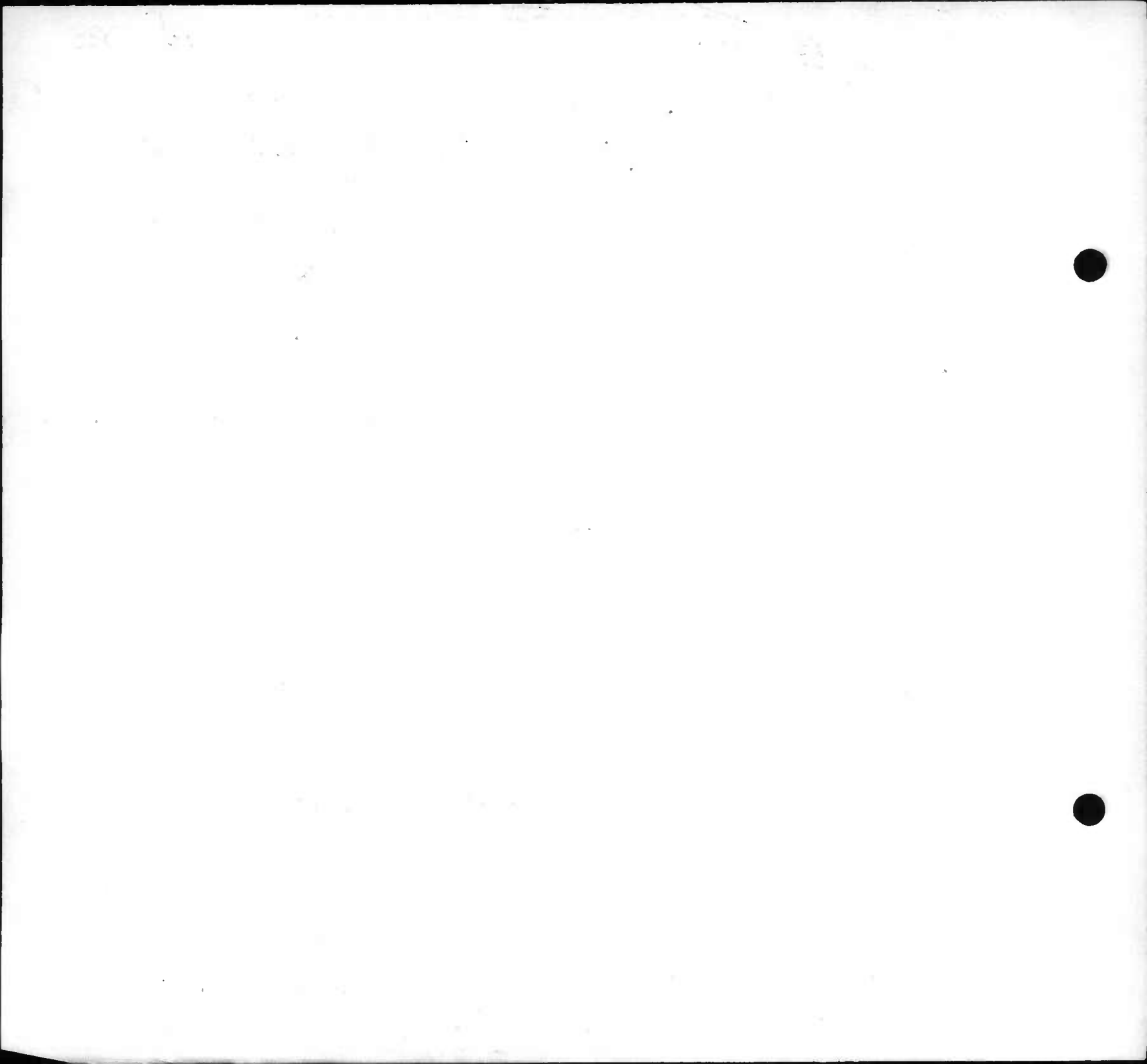
Adm: 1960.

8500 ST

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T512		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00528	
72-00528		72 00528		72 00528	
BIRTH NO. 72-00528		1. NAME OF DECEASED (Type or Print) <u>Kai Robert Thompson</u>		2. DATE AND HOUR OF DEATH <u>Jan. 16, 1972</u> <u>11:2 Noon</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>Real 2759</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Johns Hopkins Hospital</u> <u>BALTIMORE, MD 21205</u>		E. STREET AND NUMBER <u>1408 KINGSWAY ROAD</u>			
5. SEX <u>M</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/22/70</u>	9. AGE (In years last birthday) <u>2</u> year	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Robert Thompson</u>		14. MOTHER'S MAIDEN NAME <u>Carmen</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Dr. Robert Thompson</u> ADDRESS <u>1408 Kingsway Rd. 21218</u>	
18. <u>742 X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebral edema</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cardiovascular arrest</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Arrested hydrocephalus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>2 years</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>1/13/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Spasticity</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour) <u>1/13/72</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>1/13/72</u> to <u>January 16, 1972</u> and that (I) (we) last saw the deceased alive on <u>January 16, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Paul A. Shurin, M.D.</u>		23B. DATE SIGNED <u>1/16/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Paul A. Shurin</u>	
23D. ADDRESS <u>Johns Hopkins Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>1/19/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Crestlawn</u>		24D. LOCATION (City, town, or county) (State) <u>Ellicott City, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR <u>Witzke, 1630 Edmondson Avenue 21228</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-256 72 00529		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00529	
BIRTH NO.					
1. NAME OF DECEASED (Type or Print) KASEMEYER, MARGARET WILSON			2. DATE AND HOUR OF DEATH JANUARY 15, 1972 8:30 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY HOWARD C. CITY OR TOWN ELLICOTT CITY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 5106 AVOCA AVENUE - 21043		
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02/29/93	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.			13. FATHER'S NAME ROLLMAN		
14. MOTHER'S MAIDEN NAME			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS ST AGNES HOSPITAL RECORDS CATON & WILKENS AVES BALTO MD 21229		
18. 4-10-72 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH Pump failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute infarct of heart myocardial infarct 48 hrs. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A), stating the UNDERLYING CONDITION last.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If in Baltimore City, give exact location)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from 01 13 72 19 to 01 15 19 72 that (X) (we) lost saw the deceased alive on 01 15 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE JOSE APTER, M.D.			23B. DATE SIGNED 01 15 72		23C. PHYSICIAN'S NAME (Type) JOSE APTER, M.D.
24A. BURIAL CREMATION, REMOVAL (Specify) Burial			24B. DATE 1/19/72		24C. NAME of CEMETERY or CREMATORY Loudon Park
24D. LOCATION Baltimore, Maryland			25A. DATE REC'D BY HEALTH DEPT. JAN 18 1972		
25B. NAME OF REGISTRAR Witzke, 21630 Edmondson Avenue 21228			25C. FUNERAL DIRECTOR ADDRESS		

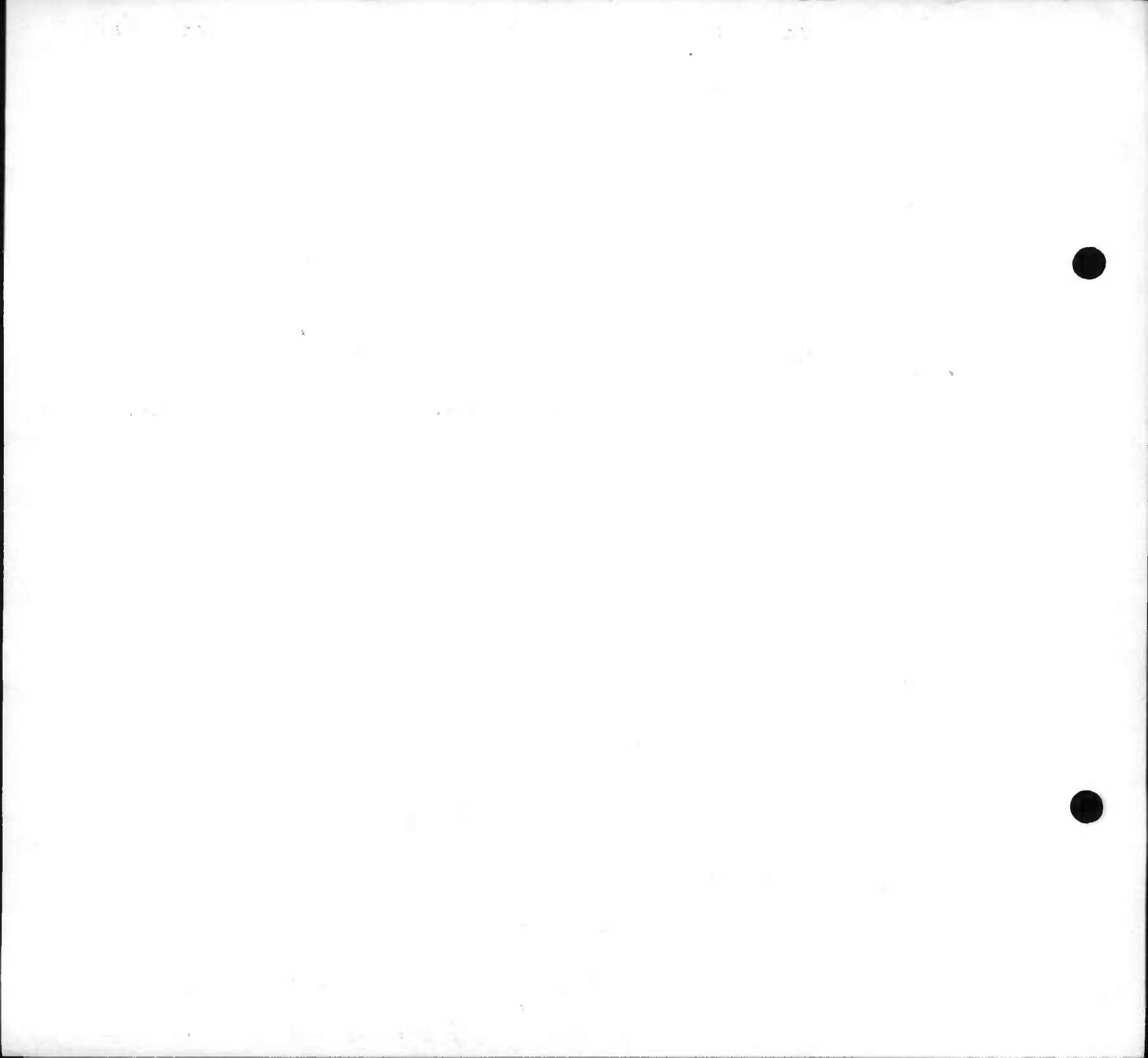
35-1053



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

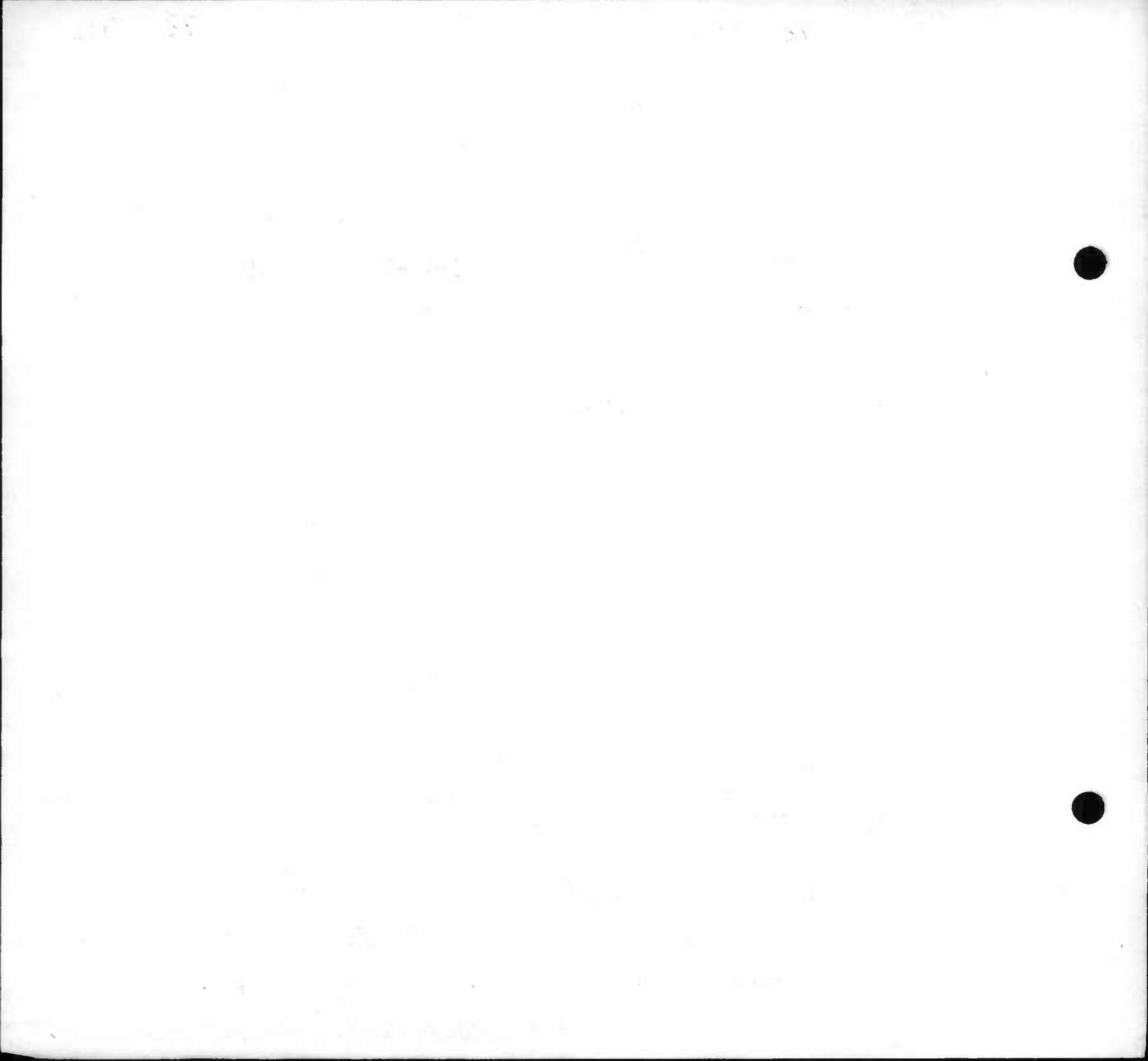
E-925 72 00530		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00530	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>ELGIN, LEROY</u>		2. DATE AND HOUR OF DEATH <u>8:30 AM</u> <u>1/17/72</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2854</u>		C. CITY OR TOWN <u>Baltimore</u>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland Gen. Hospital</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		E. STREET AND NUMBER <u>429 W. Gate Rd. Balt. Md.</u>	
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>06/19/95</u>	9. AGE (In years last birthday) <u>76</u>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Milton Elgin</u>		14. MOTHER'S MAIDEN NAME <u>Emma Hobbs</u>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-03-7967</u>		17. INFORMANT ADDRESS <u>Mrs. Ruth Elgin 429 Westgate Rd. 21229</u>	
18. <u>410.9 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> 19 <u>71</u> to <u>1/17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/7</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael A. Silverman MD</u>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/12/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Michael A. Silverman MD</u>		23D. ADDRESS <u>Maryland Gen Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/20/72</u>	24C. NAME OF CEMETERY or CREMATORY <u>Druid Ridge</u>		24D. LOCATION (City, town, or county) (State) <u>Pikesville, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Witke, 1630 Edmondson Ave. 21228</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-552 72 00531		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00531	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>James Cunningham</u>		2. DATE AND HOUR OF DEATH <u>1-17-72</u> <u>6<sup>10</sup> A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1703</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Md. Gen. Hosp.</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>Argyle Ave. 1057 Apt. 2G</u>	
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-15-12</u>	9. AGE (In years last birthday) <u>59</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>orch Operator</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>-</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>?</u>		14. MOTHER'S MAIDEN NAME <u>?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-03-7279A</u>		17. INFORMANT <u>Olive Cunningham</u> ADDRESS <u>Same</u> <u>Daughter</u>	
18. <u>402X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last		CAUSE OF DEATH (A) IMMEDIATE CAUSE: <u>?? Bronchopneumonia</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary edema</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertensive Heart disease</u> (C) <u>-</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>-</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR? <u>-</u>		22. I certify that (I) (this hospital) attended the deceased from <u>1-16</u> 19 <u>72</u> to <u>1-17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1-17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Arnold G. Alexander MD</u>		23B. DATE SIGNED <u>1-17-72</u>		23C. PHYSICIAN'S NAME (Type) <u>Arnold G. Alexander MD</u>	
23D. ADDRESS <u>827 Linden Ave Balt. Md 21201</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-21-72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Calvary Cem.</u>		24D. LOCATION (City, town, or county) <u>Baltimore, Md.</u>		24E. (State)	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1972</u>		25B. NAME OF REGISTRAR <u>Paul E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>W. J. Taylor</u> ADDRESS <u>1348 N. Calhoun St.</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-250 72 00532		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00532	
<b>CERTIFICATE OF DEATH</b>					
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		COXON, SOPHIA, E.		11/16/72 8:40 p.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			A. STATE B. COUNTY		
CHURCH HOME & HOSPITAL, BALTO., MD. 21231.			MD. BALTIMORE		
			C. CITY OR TOWN COLGATE		D. INSIDE CITY LIMITS?
			BALTO. MD.		YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>
			E. STREET AND NUMBER		
			407 NORTH POINT RD. #21224.		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. AGE (In years last birthday)
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4/26/1907	64 Yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
RETIRED		POLYSEAL CORP.		BALTIMORE, MD.	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
FREDERICK MEISENHALDER.			ELEANOR MARY LENTZ.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		216-10-7539		CHARLES F. COXON	
				ADDRESS	
				SAME	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES			Cardiac failure.		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF:		
			Metastatic carcinoma.		
			(C) DUE TO, OR AS A CONSEQUENCE OF:		
			Cardiomegaly.		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not-While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 11/14 1972 to 1/16 1972 that (I) (we) last saw the deceased alive on 1/16 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Ashwin Mehla.				1/16/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. ASHWIN MEHTA MD				Church Home & Hosp	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		1-19-72		OAK LAWN CEM.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 18 1972		J. J. J. J.		Charles F. Coxon	
				ADDRESS	
				901 S. CONKLING ST. BALTO., 21224, MD.	

14-2-34 4-22-34 10-11-34  
 19-15 10-11-34

4-22-34 10-11-34  
 19-15 10-11-34

19-15 10-11-34

19-15 10-11-34

19-15 10-11-34

19-15 10-11-34

19-15 10-11-34

19-15 10-11-34

19-15 10-11-34

19-15 10-11-34

19-15 10-11-34

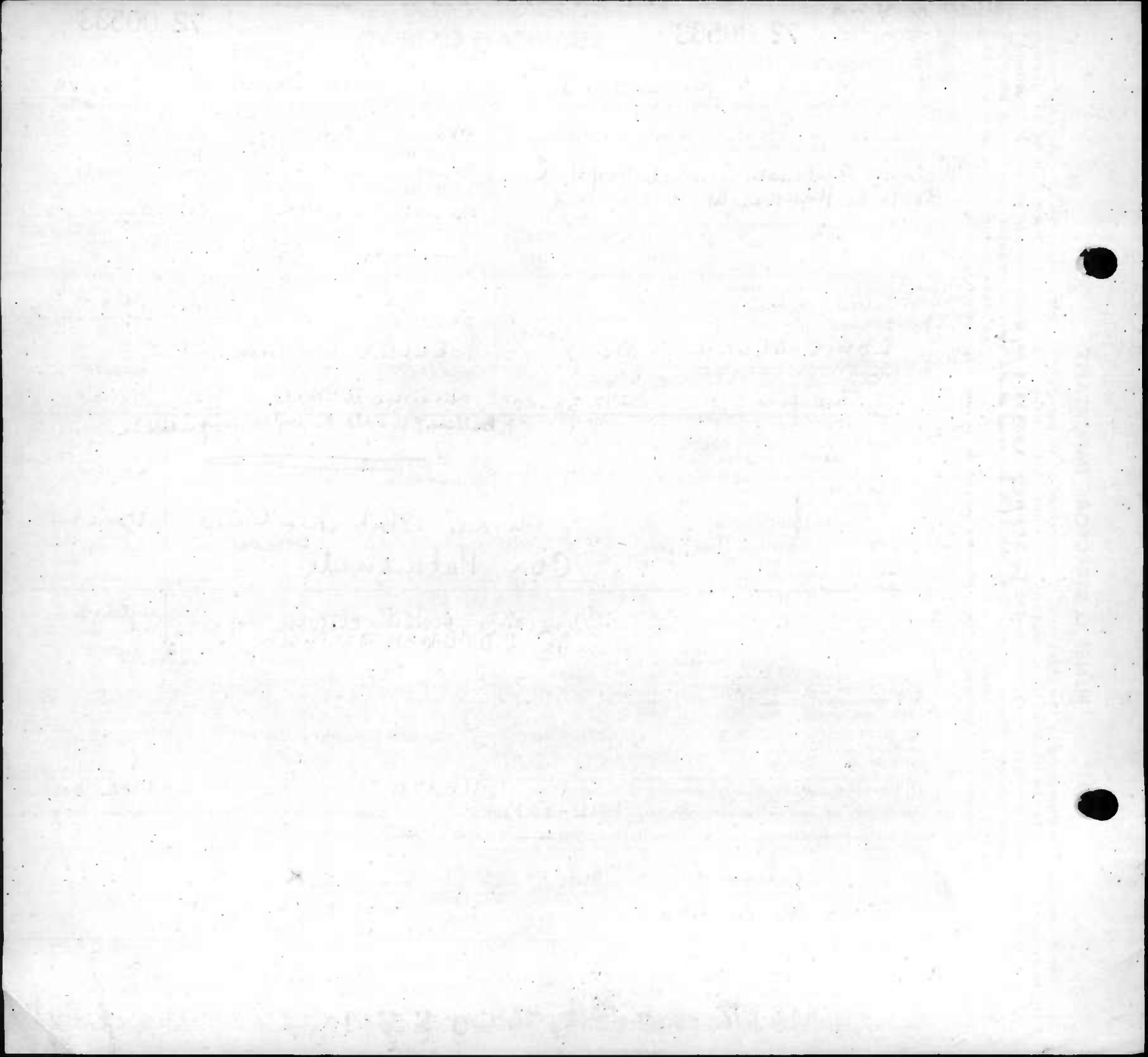
19-15 10-11-34

19-15 10-11-34

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-350 72 00533		BALTIMORE CITY HEALTH DEPARTMENT		X REG. NO. 72 00533	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Madden Robert J</b>		2. DATE AND HOUR OF DEATH <b>1-12-1972 at 7-35 PM. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>AA.</b>		5. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>South Baltimore General Hospital 3001-S. Hanover St, Balto, Md 21230.</b>		E. STREET AND NUMBER <b>106 WAYWICK SHIRE LANE - GLENBURIE 21061</b>			
5. SEX <b>M</b>	6. RACE <b>B</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-10-15</b>	9. AGE (In years last birthday) <b>56</b>	10. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Disabled - Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>S.C.</b>	
13. FATHER'S NAME <b>Louis Madden (Dec.)</b>		14. MOTHER'S MAIDEN NAME <b>Ellier Madden</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>unknown.</b>		16. SOCIAL SECURITY NO. <b>247-30-0504</b>		17. INFORMANT <b>Nannie B. Madden (wife)</b> ADDRESS <b>Same</b>	
18. <b>579.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Failure</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Chronic Obstructive Lung Disease</b>		APPROXIMATE INTERVAL ONSET AND DEATH <b>Several months</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Generalized Arteriosclerosis w/ Coronary occlusion</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Cor Pulmonale</b>		<b>years.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>		(C) <b>Generalized Arteriosclerosis w/ Coronary occlusion</b>		<b>years.</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>1-11-1972</b> 19 to <b>1-12-1972</b> 19, that (I) (we) last saw the deceased alive on <b>1-12-1972</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>ahmed</b> <b>Md.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>DR. AHMAD</b>		23D. ADDRESS <b>3001-S. Hanover St, Baltimore, Md 21230.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>1-17-72</b>	24C. NAME OF CEMETERY or CREMATORY <b>LIBERTY CHURCH</b>		24D. LOCATION (City, town, or county) (State) <b>Laurens Co, S.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Md.</b>		25C. FUNERAL DIRECTOR <b>MARY ELZAN - 802 MADISON AVE, Balto.</b>	

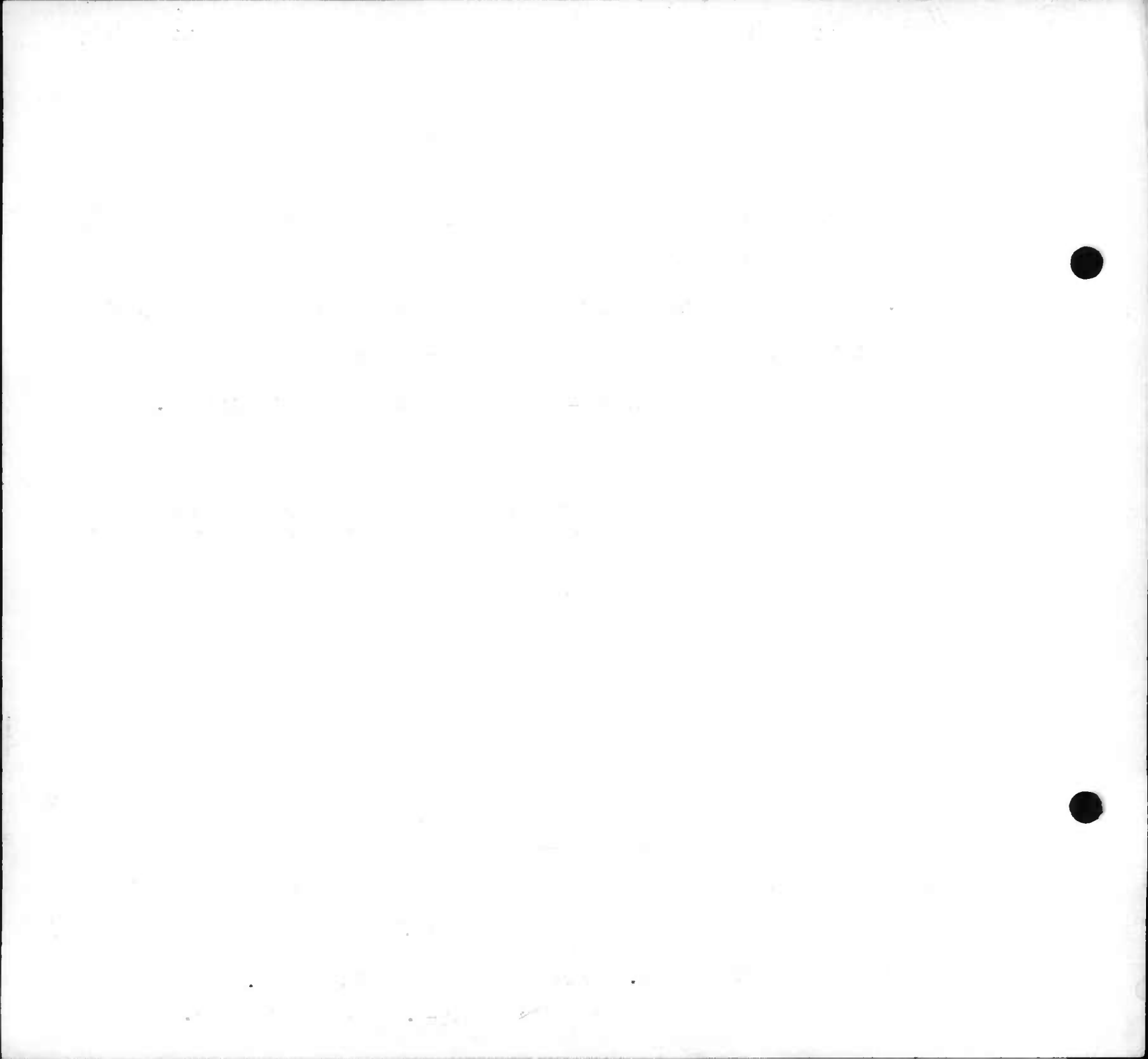




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

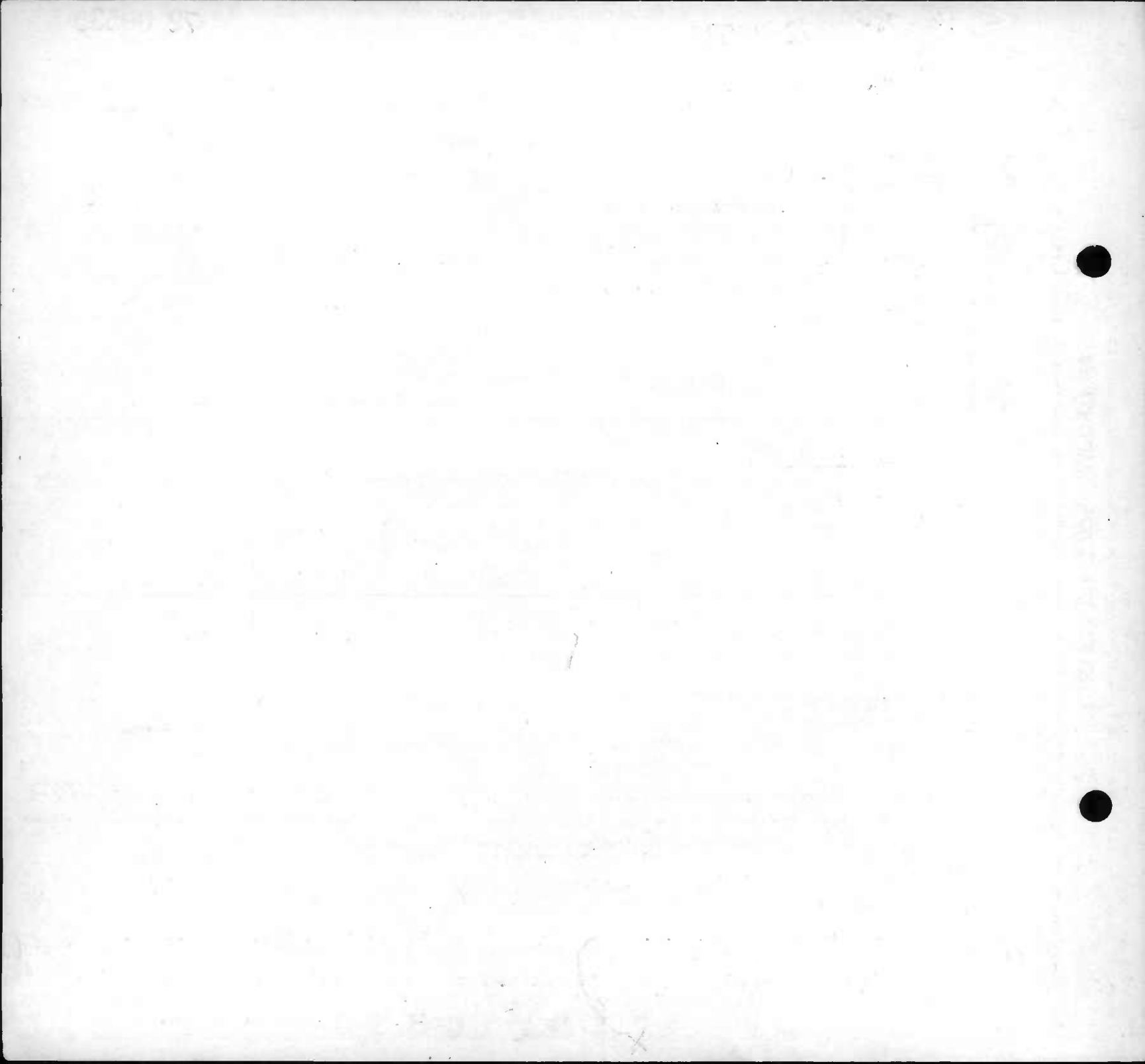
H200 72 00534		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00534	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) RILEY HOOKS		2. DATE AND HOUR OF DEATH 11/10/72 11:35 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1762		C. CITY OR TOWN BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION MARYLAND GENERAL +8 HOSPITAL		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1102 DRUID HILL AVENUE, 21217		5. SEX M		6. RACE NEGRO	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10/16/03		9. AGE (In years last birthday) 68	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10B. KIND OF BUSINESS OR INDUSTRY C/c Of Baltimore		11. BIRTHPLACE (State or foreign country) VIRGINIA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME William Hooks		14. MOTHER'S MAIDEN NAME Luce Cook	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 220-07-5614		17. INFORMANT Flora Hooks 1102 Druid Hill Ave.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH MYOCARDIAL INFARCTION (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROSIS & HYPERTENSIVE (B) CARDIO-VASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HR YRS	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (this hospital) attended the deceased from DEC 7, 19 71 to JAN 10, 19 72 that (we) last saw the deceased alive on JAN 10, 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.					
23A. SIGNATURE Artemio M. Cuevas, Jr. MD		23B. DATE SIGNED 1/10/71		23C. PHYSICIAN'S NAME (Type) ARTEMIO M. CUEVAS, JR. MD	
23D. ADDRESS Maryland General Hospital		24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/14/72	
24C. NAME OF CEMETERY OR CREMATORY Mt. Arburn		24D. LOCATION (City, town, or county) (State) Baltimore MD.		25A. DATE REC'D. BY HEALTH DEPT. JAN 18 1972	
25B. NAME OF REGISTRAR Mary E. Law		25C. FUNERAL DIRECTOR 802 Madison Ave.		ADDRESS	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-260 72 00535		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00535	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		ANNIE H. BAKER		JANUARY 13, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		M.	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE Maryland		B. COUNTY	
90 Mt. Sinai Nursing Home		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
4613 Park Heights Avenue		E. STREET AND NUMBER 301 McMechen Street			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> Separated <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years lost birthday)	10. If Under 1 Yr. Months Days
Female	Colored		Sept. 15, 1898	73	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
None				Baltimore, Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Unknown		Unknown		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				Doris Hill - 3404 Alto Road	
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septicemia (B) DUE TO, OR AS A CONSEQUENCE OF: Infected amputated Stump - (C) Diabetes Mellitus		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day 5 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Osteoarthritis, Arteriosclerosis, general.			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from 11/30 1971 to 1/13 1972, that (1) (we) last saw the deceased alive on 1/13 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Stanley D. Madison, M.D.				23B. DATE SIGNED 1/18/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Stanley D. Madison, M.D.				1133 Pennsylvania Ave., Balto., Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1-18-72		Arbutus Memorial Park	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 18 1972		Mary E. Law		802 Madison Ave.	



72 00536

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00536

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES E. DUPRE</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 8, 1972</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 8, 1972 4:20 A</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>17, April 1943</b>		10. AGE (In years last birthday) <b>28</b>	
11. BIRTHPLACE (State or foreign country) <b>N/C</b>		12. CITIZEN OF <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>L. Homes</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) <b>No.</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Miss Minnie White 815 Mc Aleer Ct.</b>	
19. CAUSE OF DEATH <b>2-966 I X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>in front of 1211 Urban Way 2636</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>1-8-72 3:10 A</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Stabbed during altercation</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-8-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/17/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Talbot, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Mary-E. Law</b>		ADDRESS <b>802 Madison Ave.</b>	

ACADEMY OF CONTENT

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00537</b>	
BIRTH NO. <b>72 00537</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>MISS ALICE LEE</b>		2. DATE AND HOUR OF DEATH <b>16 Jan 72 12:15 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital.</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>Baltimore.</b> C. CITY OR TOWN <b>Baltimore.</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>Coleherne Rd. 4638.</b>	
5. SEX <b>F.</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-14-99</b> 9. AGE (in years last birthday) <b>73</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None.</b>		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>George Town, S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Julia Bryant</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>250-90-0102</b>	
17. INFORMANT <b>Mattie Washington</b>		ADDRESS <b>4638 Coleherne Rd.</b>	
18. <b>250.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiorespiratory failure</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD.</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetes Mellitus &amp; acidosis.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION <b>15 Jan 72</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>15 Jan 1972</b> to <b>16 Jan 1972</b> that (I) (we) last saw the deceased alive on <b>15 Jan 1972</b> and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>R. C. Mitra</b>		23B. DATE SIGNED <b>16 Jan. 72.</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. R.C. MITRA, MD.</b>		23D. ADDRESS <b>The Provident Hospital.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE <b>1-22-72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Bethel A.M.E. Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Georgetown, S.C.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>	25B. NAME OF REGISTRAR <b>R. S. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR <b>Vanhook Jones</b> ADDRESS <b>1701 L... ..</b>	

1-14-43

x

James O. Jones

1-14-43

1-14-43

1-14-43

1-14-43



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. <u>192800538</u>	
BIRTH NO. <u>72 00538</u>		1. NAME OF DECEASED (Type or Print) <u>Lavinia Briscoe</u>	
2. DATE AND HOUR OF DEATH <u>Jan. 15, 1972</u> <u>1 6:25 A.M.</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>George Washington Nursing Home</u> <u>90</u>	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1701</u>		5. STREET AND NUMBER <u>607 Pennsylvania Ave.</u>	
6. CITY OR TOWN		7. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. SEX <u>Fem.</u>	9. RACE <u>Negro</u>	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	11. DATE OF BIRTH <u>1-1-91</u>
12. AGE (in years last birthday) <u>81</u>		13. If Under 1 Yr. Months: Days: Hours: Min.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. KIND OF BUSINESS OR INDUSTRY	
16. BIRTHPLACE (State or foreign country) <u>Baltimore Co.</u>		17. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
18. FATHER'S NAME <u>Jim Henson</u>		19. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>	
20. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		21. SOCIAL SECURITY NO. <u>215-10-6624A</u>	
22. INFORMANT <u>Chart</u>		23. ADDRESS <u>607 Pennsylvania Ave.</u>	
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		25. CAUSE OF DEATH <u>DUCTAL ADENOCARCINOMA BREAST</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive Failure</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Atherosclerosis</u> (C) <u>UREMIA</u>	
26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 MOS.</u>		27. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
28. MEDICAL CERTIFICATION 19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
29A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		29B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
29C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		29D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
29E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		29F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>12-16-1971</u> to <u>1-15-1972</u> that (1) (we) last saw the deceased alive on <u>1-14-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Richard L. Tyson</u>		23B. DATE SIGNED <u>1-15-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Richard F. Tyson, M.D.</u>		23D. ADDRESS <u>936 W. North Avenue</u> <u>Baltimore, Maryland 21217</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-20-72</u>	
24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>	
25C. FUNERAL DIRECTOR <u>Walter J. Taylor</u>		25D. ADDRESS <u>4701 - Laurel St.</u>	

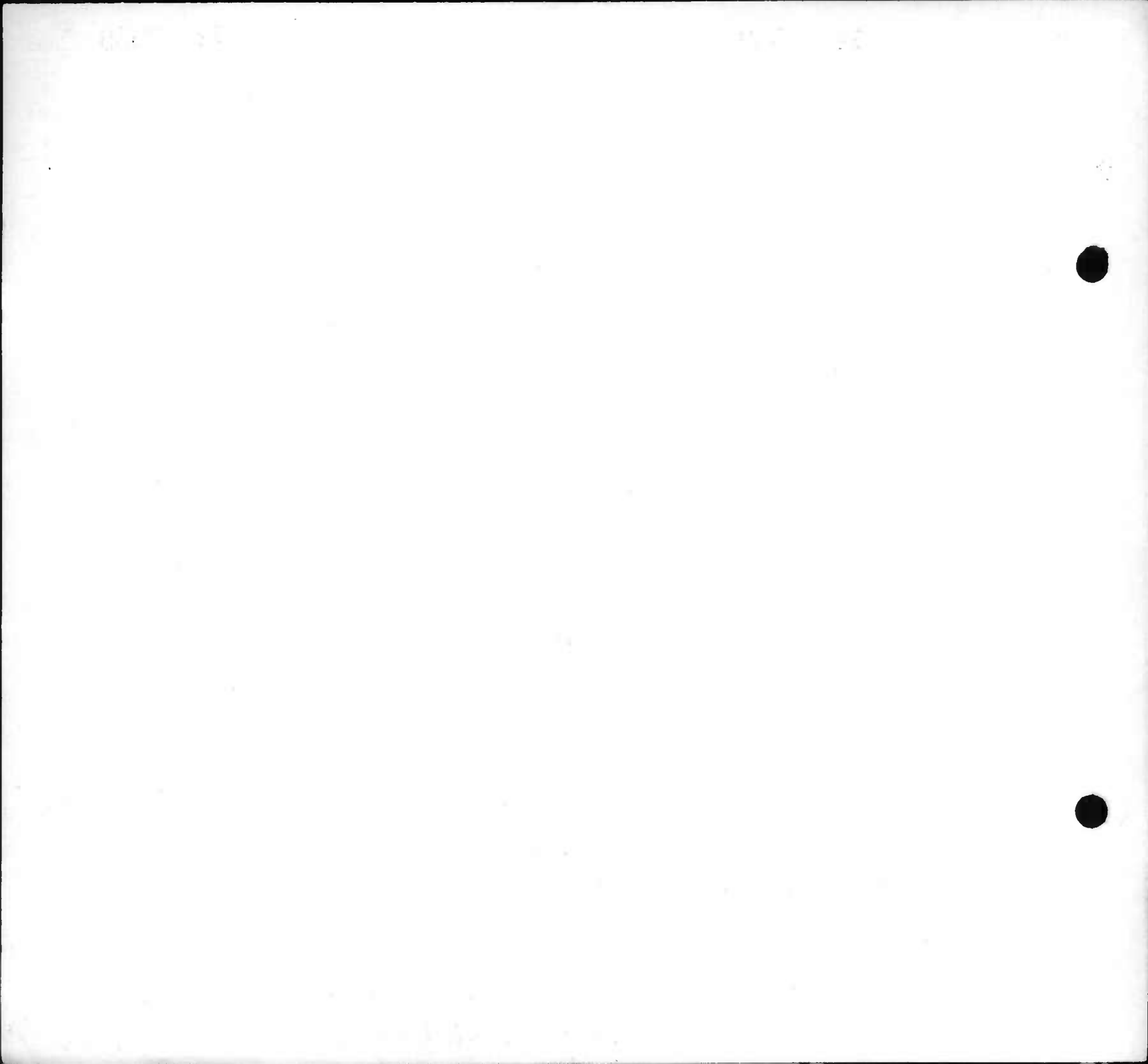
7

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P3621

BALTIMORE CITY HEALTH DEPARTMENT				72 00539		CERTIFICATE OF DEATH		REG. NO. 72 00539	
BIRTH NO. 72 00539				1. NAME OF DECEASED (Type or Print) <u>Patterson Susie S</u>		2. DATE AND HOUR OF DEATH <u>1-16-72</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University of Md. Hospital</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>1701</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u>		6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-25-13</u>		9. AGE (in years last birthday) <u>58</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Richmond, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown</u>			
16. SOCIAL SECURITY NO. <u>217-07-8712</u>				17. INFORMANT <u>Eva Scott, 351 George St, 21201</u>				ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Hypertensive Cardiovascular Disease</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Disease</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>&gt; 2 yrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<u>Chronic</u>					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>6 Jan</u> 19 <u>72</u> to <u>17 Jan</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>17 Jan</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Alva S. Baker, M.D.</u>				23B. DATE SIGNED				23C. PHYSICIAN'S NAME (Type) <u>ALVA S. BAKER M.D.</u>	
23D. ADDRESS <u>Univ. of Md. Hospital</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>					
24B. DATE <u>1-19-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Auburn</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 18 1972</u>			
25B. NAME OF REGISTRAR <u>E. G. Galt</u>				25C. FUNERAL DIRECTOR <u>Roberton Dyett F.H.</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 00540	
BIRTH NO. 72 00540		1. NAME OF DECEASED (Type or Print) <i>Baca, Filiberto</i>		2. DATE AND HOUR OF DEATH <i>Jan. 14, 1972 9 55 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>39 Provident Hosp.</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE <i>Maryland</i> B. COUNTY <i>V 28</i>			
				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <i>205 Barreras Circle, Socorro, N. M.</i>			
5. SEX <i>M</i>	6. RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>4-9-06</i>	9. AGE (In years last birthday) <i>65</i>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>none</i>		11. BIRTHPLACE (State or foreign country) <i>New Mexico</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Dean</i>				14. MOTHER'S MAIDEN NAME <i>Juanita</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs. Rosie Karomwall</i>		ADDRESS <i>4313 Liberty Hghts</i>	
18. <i>4-10-72</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <i>Acute Myocardial infarction (Inferior)</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  <i>Arteriosclerotic cardiovascular</i>			
				(B) DUE TO, OR AS A CONSEQUENCE OF: <i>acute pulmonary edema</i>			
				(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>Jan. 14</i> 19 <i>72</i> to <i>Jan. 14</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>Jan. 14</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>V. Chitraplee</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>Jan. 14, 1972</i>	
23C. PHYSICIAN'S NAME (Type) <i>V. Chitraplee</i>				23D. ADDRESS <i>Provident Hosp.</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>BURIAL</i>		24B. DATE <i>1/20/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Socorro Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>Socorro, New Mexico</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 18 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor MD</i>		25C. FUNERAL DIRECTOR <i>MORTON &amp; DYETT FUNERAL HOME</i>		ADDRESS <i>1701 Laurens St. Balto., Md.</i>	

July 19

July 19

July 19

July 19

July 19

July 19

July 19

July 19

July 19

July 19

July 19

July 19

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00541</b>	
72 00541		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>George A. Gross</b>		1-16-72	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Md.	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 931 Bentalou Street, North</b>		B. COUNTY <b>1605</b>	
		C. CITY OR TOWN Baltimore	
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>931 Bentalou Street</b>	
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-12-96
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY Retired	9. AGE (in years last birthday) 75
11. BIRTHPLACE (State or foreign country) Leonardtown, Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Daniel Gross		14. MOTHER'S MAIDEN NAME Mary Ellen Gross	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-14-7207	17. INFORMANT Mrs. Beatrice Gross 931 N. Bentalou St.
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Colon</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>Jan 6 1972</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cancer of Colon</b>	
20A. AUTOPSY? (Yes or No) <b>no</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 15 1972</b> to <b>Jan 16 1972</b> that (I) (we) last saw the deceased alive on <b>Jan 15 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Benjamin A. Doyan</b>		23B. DATE SIGNED <b>1-18-72</b>	
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-20-72	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Park		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1972		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett Funeral Home</b>		ADDRESS 1701 Laurens St.	

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100

100



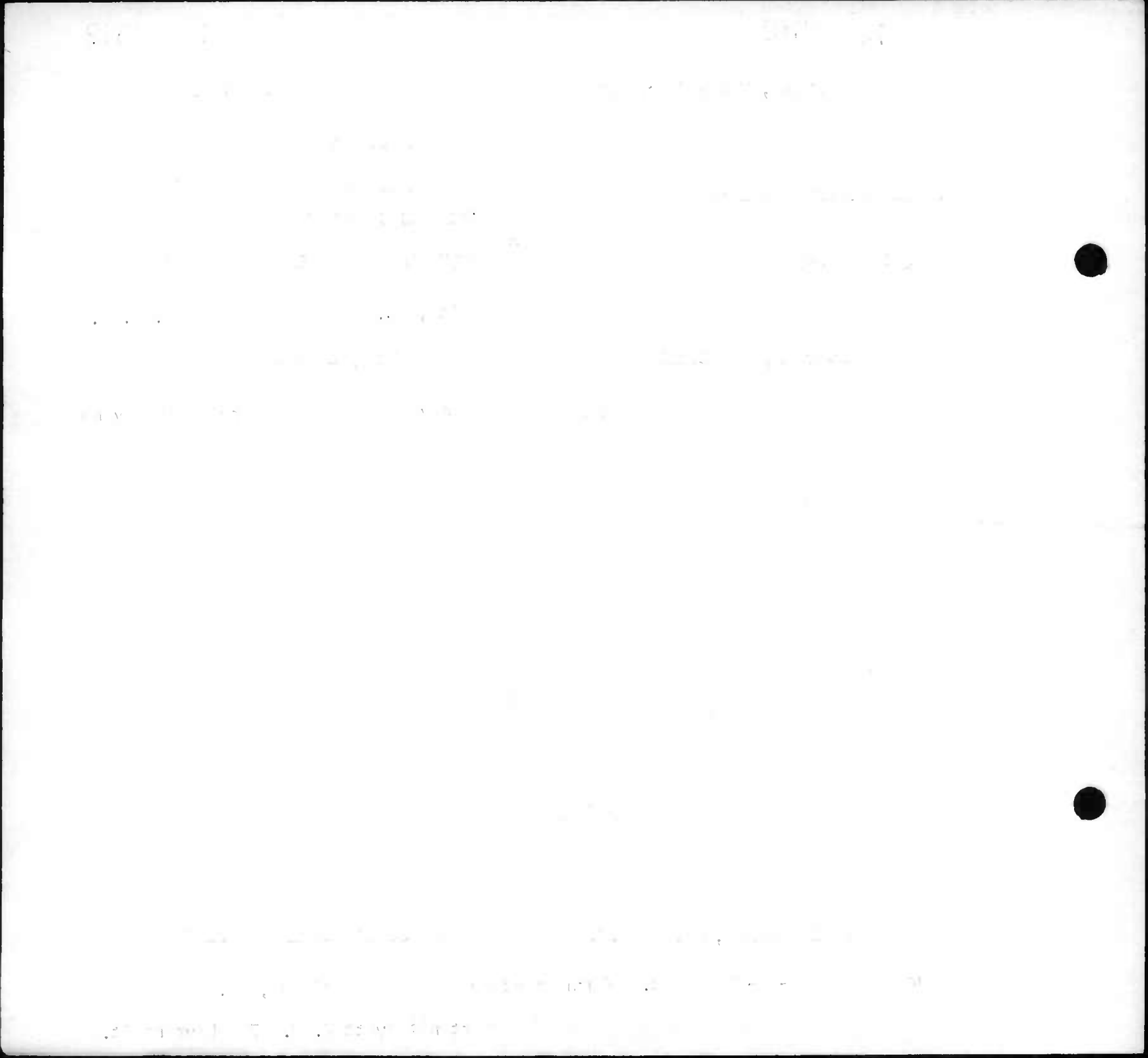
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 00542

72 00542  
BIRTH NO. 71-20324

1. NAME OF DECEASED (Type or Print) <b>ADAMS, VAN NESS XAVIER</b>			2. DATE AND HOUR OF DEATH <b>01/16/72 7:03pm</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHNS HOPKINS HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1202 MC CULLOUGH ST</b>		
5. SEX <b>male</b>	6. RACE <b>negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/20/71</b>	9. AGE (In years last birthday) <b>2mo 1mo</b>	If Under 1 Yr. Months Days <b>11 20</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Balto, Md.</b>	
13. FATHER'S NAME <b>Anderson, Cecil</b>			12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Cheryl Adams</b>	
				ADDRESS <b>1234 Druid Hill Avenue</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) <b>Aspiration</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Amphalocle &amp; Dystrochium</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Immaturity</b> (C) <b>Leukemia S/P repair of Dystrochium</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>25 min</b>					
MEDICAL CERTIFICATION OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Leukemia S/P repair of Dystrochium</b>					
19A. DATE OF OPERATION <b>11/27/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Dystrochium</b>		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>12/31</b> 19 <b>71</b> to <b>1/16</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/14</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Levi Watkins Jr.</b>				23B. DATE SIGNED <b>1/16/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>LEVI WATKINS, JR. M.D.</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-19-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION <b>Baltimore, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>Morton E. Dyett</b>			
		ADDRESS <b>F. H. 1701 Laurens St.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

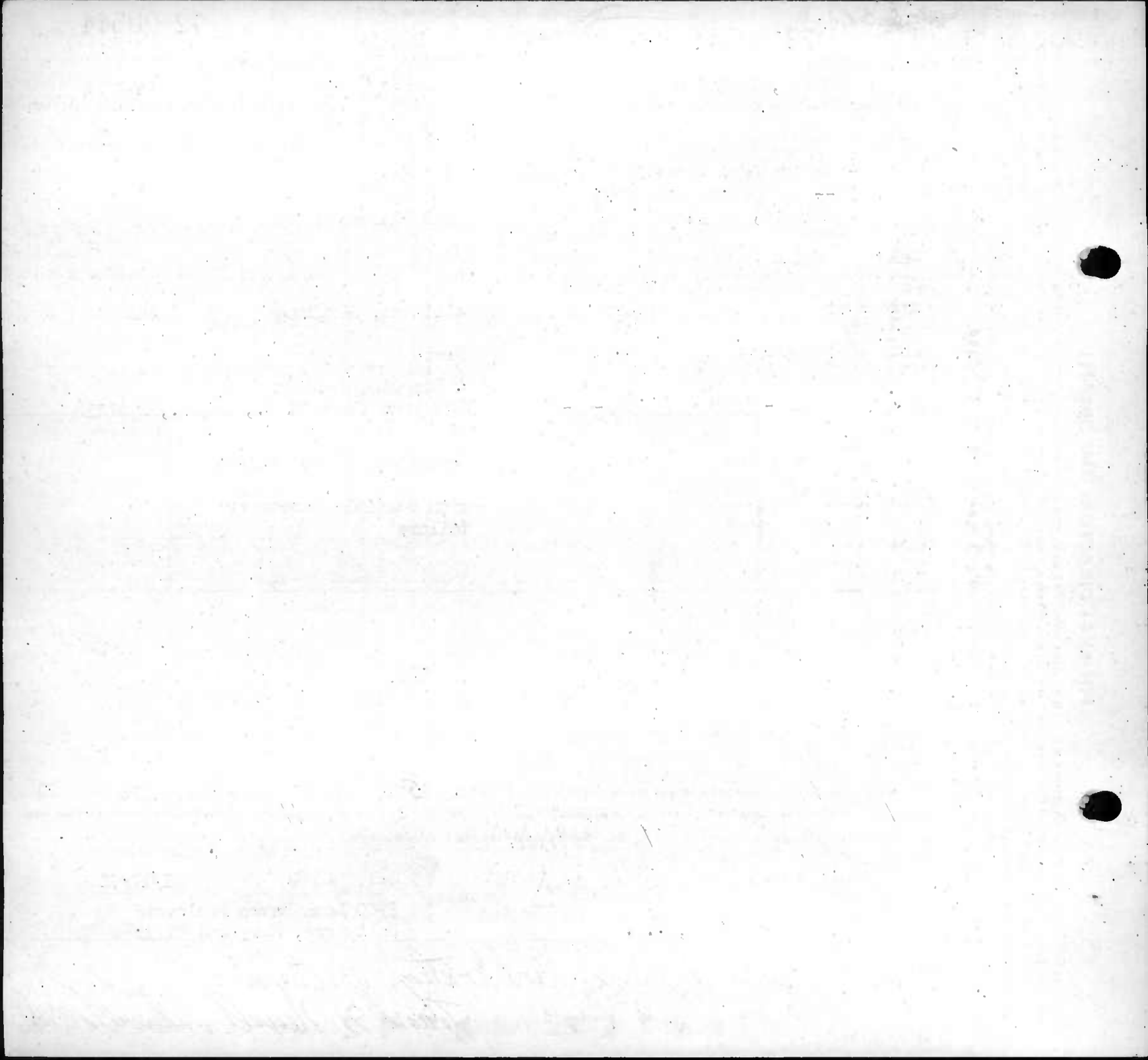
72 00543		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00543	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EVELYN COOPER</b>		2. DATE AND HOUR OF DEATH <b>1-15-72</b> <b>8:15 P.</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>90 CRAWFORD NURSING HOME 2117 Dension Street Baltimore, Maryland</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1547</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>Female</b> 6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-6-86</b> 9. AGE (in years last birthday) <b>86</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Unknown</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>		12. CITIZEN OF WHAT COUNTRY?	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>212-26-1382A</b>		17. INFORMANT ADDRESS <b>Mrs. Marie Fox 2117 Dennison St.</b>	
18. <b>43311</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral thrombosis</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral thrombosis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED White At <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 10 1970</b> to <b>Jan 15 1972</b> that (I) (we) lost saw the deceased alive on <b>Jan 14 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Abraham B. Hurwitz M.D.</b>		23B. DATE SIGNED <b>1-18-72</b>		23C. PHYSICIAN'S NAME (Type) <b>Abraham B. Hurwitz, M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-18-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. NAME OF REGISTRAR <b>Morton &amp; Overt F.H.</b>		24F. ADDRESS <b>1701 Laurens St. Baltimore, Maryland 21217</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor M.D.</b>		25C. FUNERAL DIRECTOR <b>Morton &amp; Overt F.H.</b>	

No one qualified to give  
info. at N.H. To call  
back later,

# FUNERAL DIRECTOR: IMPORTANT

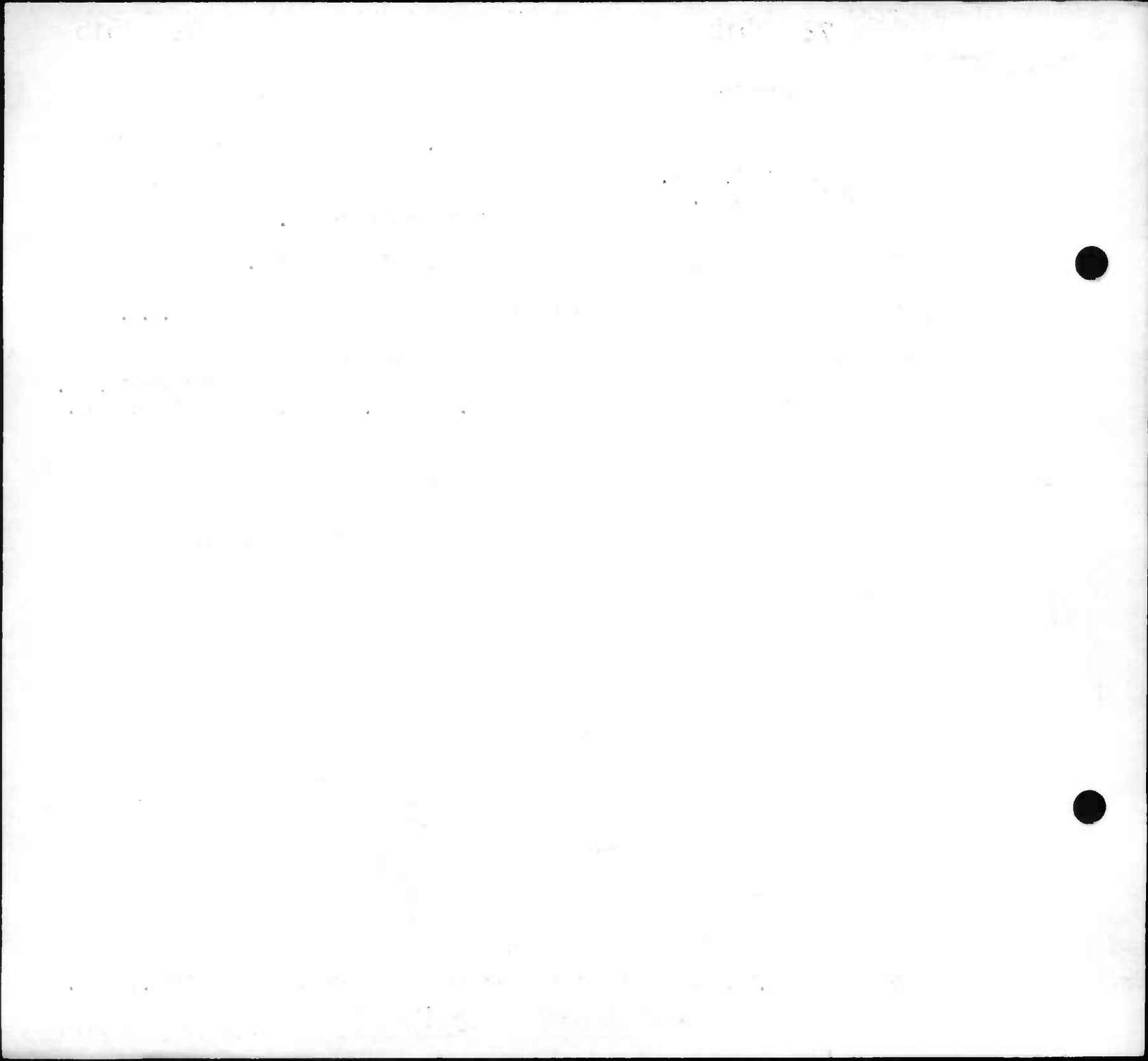
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-650		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO. 72 00544	
BIRTH NO. 72 00544		CERTIFICATE OF DEATH					
1. NAME OF DECEASED (Type or Print) WARREN, THOMAS O				2. DATE AND HOUR OF DEATH 1/17/72 1:55 A M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 23 Veterans Administration Hospital 3900 Loch Raven Boulevard Baltimore, Maryland 21218				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY BALTO C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 213 Clardndon Ave			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/2/92	9. AGE (In years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) caretaker		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) caretaker			10B. KIND OF BUSINESS OR INDUSTRY Pikesville Armory		12. CITIZEN OF WHAT COUNTRY? USA		
13. FATHER'S NAME John Wesley Warren				14. MOTHER'S MAIDEN NAME Fresh			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes 1916 - 1919		16. SOCIAL SECURITY NO. 213-05-9432		17. INFORMANT VA Hospital Records 3900 Loch Raven Blvd., Balto., Md 21218		ADDRESS	
18. 4 27.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Congestive heart failure with possible pacemaker failure ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION 2 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) YES 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from January 15th 19 72 to January 17th 19 72, that (1) (we) last saw the deceased alive on January 17th 19 72 and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.							
23A. SIGNATURE Lawrence Mills, M.D.				23B. DATE SIGNED 1/17/72			
23C. PHYSICIAN'S NAME (Type) LAWRENCE MILLS, M.D.				23D. ADDRESS 3900 Loch Raven Boulevard Baltimore, Maryland 21218			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial Jan 20 1972		Jan 20 1972		Landon Park Cemetery Baltimore		Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1972		25B. NAME OF REGISTRAR M.D.		25C. FUNERAL DIRECTOR Frank H. Newell		ADDRESS Baltimore, Md.	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 00545		BALTIMORE CITY HEALTH DEPARTMENT		72 00545	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>John Lee Wehage</b>			2. DATE AND HOUR OF DEATH <b>January 13, 1972</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3311 Parkington Ave. Baltimore 15, Md.</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2740</b>		
5. SEX <b>Male</b>			6. RACE <b>White</b>		
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>Oct 9, 1878</b>		
9. AGE (in years last birthday) <b>93 yrs.</b>			10. AGE (in years last birthday) <b>93 yrs.</b>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Wilson Steamship Lines Maryland</b>		
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>			12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
13. FATHER'S NAME <b>John Wehage</b>			14. MOTHER'S MAIDEN NAME <b>Louise Winters</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-22-0294</b>		
17. INFORMANT <b>Mrs. Edith E. Wehage, 3311 Parkington Ave.</b>			18. ADDRESS <b>Baltimore 15, Md.</b>		
18. CAUSE OF DEATH <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial infarction</b> <b>5 minutes</b> <b>Many years</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 minutes</b> <b>Many years</b>		
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>II</b>					
19A. DATE OF OPERATION <b>1/10/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20A. DATE OF OPERATION <b>1/10/72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20C. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>March 29, 1968</b> to <b>January 13, 1972</b> that (I) <del>we</del> last saw the deceased alive on <b>Jan 10, 1972</b> and that in (my) <del>our</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>we</del> (did not) view the body after death.					
23A. SIGNATURE <b>Seymour H. Rubin, M.D.</b>		23B. DATE SIGNED <b>1/14/72</b>		23C. ADDRESS <b>5715 Park Heights Ave</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 17, 1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>Druid Ridge Cemetery</b>	
24D. LOCATION <b>Pikesville, Baltio., Md.</b>		24E. NAME OF REGISTRAR <b>Frank D. Newell</b>		24F. FUNERAL DIRECTOR <b>Frank D. Newell</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>Frank D. Newell</b>		25C. FUNERAL DIRECTOR <b>Frank D. Newell</b>	

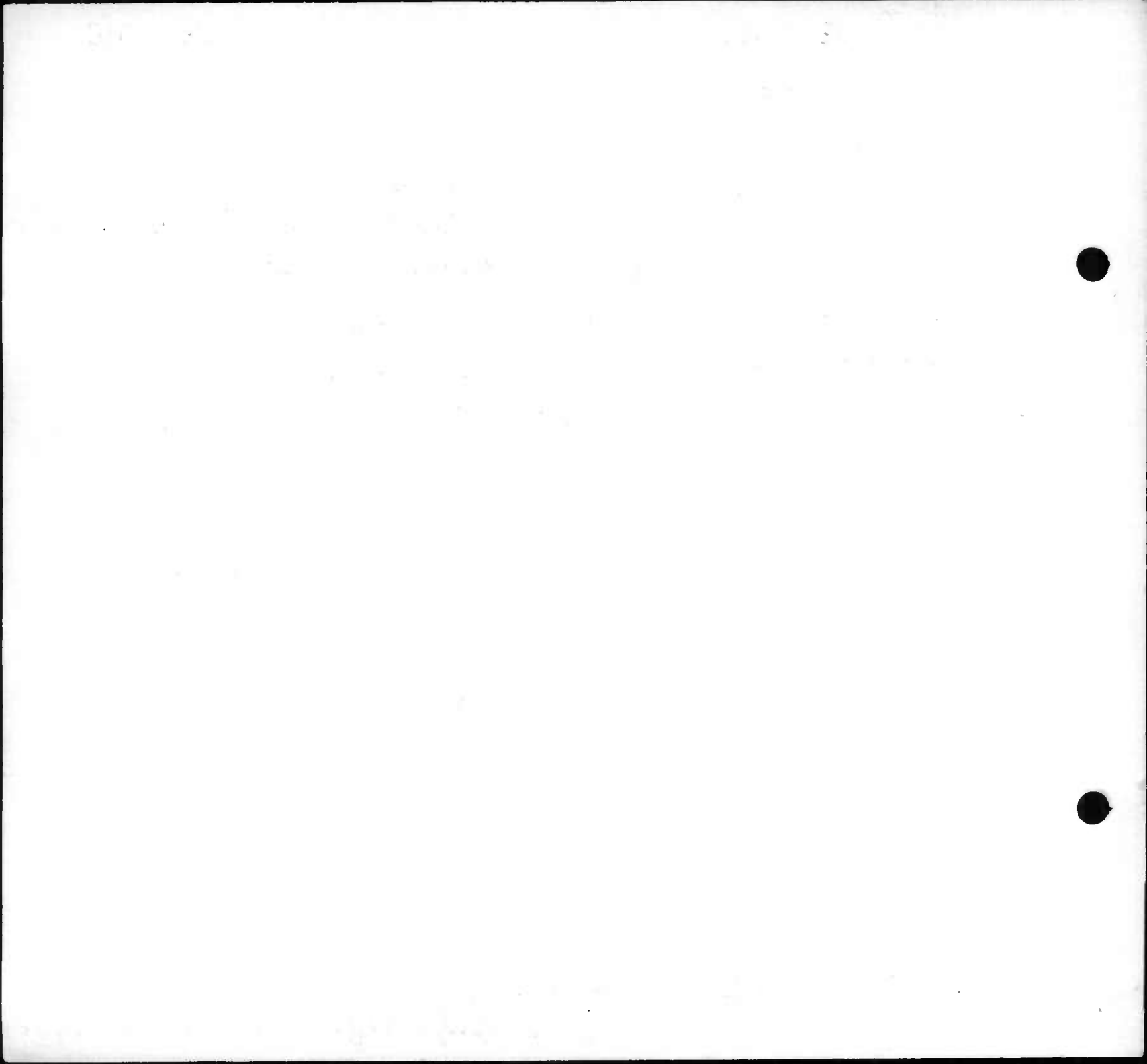




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>BIRTH NO.</b> <span style="font-size: 1.5em;">72 00546</span></p>		<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p>		<p><b>CERTIFICATE OF DEATH</b></p>		<p><b>REG. NO.</b> <span style="font-size: 1.5em;">72 00546</span></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">FRANCIS RASPA</span></p>				<p><b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">1. 11. 1972 5:20 A.M.</span></p>			
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>				<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission) A. STATE <span style="font-size: 1.2em;">MD</span> B. COUNTY <span style="font-size: 1.2em;">2652</span></p>			
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">LUTHERAN HOSP OF MARYLAND</span> <span style="font-size: 1.5em;">46</span></p>				<p><b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span></p>		<p><b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p><b>5. SEX</b> <span style="font-size: 1.2em;">Female</span></p>		<p><b>6. RACE</b> <span style="font-size: 1.2em;">White</span></p>		<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>		<p><b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">4-12-86</span></p>	
<p><b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">85</span></p>		<p><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">housewife</span></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">HOME</span></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">ITALY</span></p>	
<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">Italy-</span></p>				<p><b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Anthony Saccone</span></p>			
<p><b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Gaetana Fiore</span></p>				<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span></p>			
<p><b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">219-094409A</span></p>				<p><b>17. INFORMANT</b> <span style="font-size: 1.2em;">Mrs. DeLuia</span></p>			
<p><b>18. CAUSE OF DEATH</b></p>				<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>			
<p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p>				<p><b>(A) IMMEDIATE CAUSE</b> <span style="font-size: 1.2em;">MYOCARDIAL INFARCTION</span> <b>DUE TO, OR AS A CONSEQUENCE OF:</b></p>			
<p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>				<p><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <span style="font-size: 1.2em;">Atherosclerotic Cardiovascular disease</span></p>			
<p><b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> <span style="font-size: 1.2em;">Pneumonia</span></p>				<p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>			
<p><b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">7-10-91</span></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.2em;">Yes</span></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)</p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)</p>	
<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>		<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <span style="font-size: 1.2em;">1. 11. 1972</span> <b>to</b> <span style="font-size: 1.2em;">1. 11. 1972</span> <b>that (I) (we) last saw the deceased alive on</b> <span style="font-size: 1.2em;">1. 11. 1972</span> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.</b> (I) (We) (did) (did not) view the body after death.</p>			
<p><b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Dr. Aziz Arain MD</span></p>				<p><b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">1. 11. 1972</span></p>		<p><b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">DR. AZIZ ARAIN MD</span></p>	
<p><b>23D. ADDRESS</b> <span style="font-size: 1.2em;">730 ARTHUR ST. BALD 21216</span></p>				<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span></p>			
<p><b>24B. DATE</b> <span style="font-size: 1.2em;">1/14/72</span></p>		<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Gardens of Faith</span></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Baltimore</span></p>		<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JAN 18 1972</span></p>	
<p><b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">Rosa E. Jones</span></p>				<p><b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">Joseph J. Bennett</span></p>			
<p><b>ADDRESS</b> <span style="font-size: 1.2em;">263 S. Conkey St</span></p>				<p><b>VS 150-REV. 1/1/68</b></p>			



4500		72 00547		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00547	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
HOFMAN, ELIZABETH C.				Jan. 16 1972 9 49 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
Baltimore City Hospitals				Maryland			
31 4940 Eastern Avenue				C. CITY OR TOWN D. INSIDE CITY LIMITS?			
Baltimore, Md. 21224				Baltimore YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX 6. RACE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 9. AGE (In years last birthday) 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			
Female Caucasian				6-19-1881 90 Housewife			
11. BIRTHPLACE (State or foreign country)				12. CITIZEN OF WHAT COUNTRY?			
Maryland				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Leopold Ruppel				Mary			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
no				213-50-0861			
17. INFORMANT				ADDRESS			
Records: BCH-4940 Eastern Avenue				21224			
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				16 hours			
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES				Acute myocardial infarction			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) Prolonged arteriosclerosis many years			
II				(C) X X X X X X X X X X			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				Organic brain syndrome			
19A. DATE OF OPERATION				20A. AUTOPSY? (Yes or No)			
2				Yes			
19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? (Notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
<input type="checkbox"/>				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)				21E. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from Jan. 16 1972 to Jan. 16 1972				that (I) last saw the deceased alive on Jan. 16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE				23B. DATE SIGNED			
Jay E. Menitove, M.D.				1-16-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
Jay E. Menitove, M.D.				Balt. City Hosps., Balt. Md 21224			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE			
Burial				1/20/72			
24C. NAME of CEMETERY or CREMATORY				24D. LOCATION (City, town, or county) (State)			
Sacred Heart Cemetery				Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT.				25C. FUNERAL DIRECTOR			
JAN 18 1972				Joseph N. Zannino - 263 S Conkling St.			



sin

in the

and the

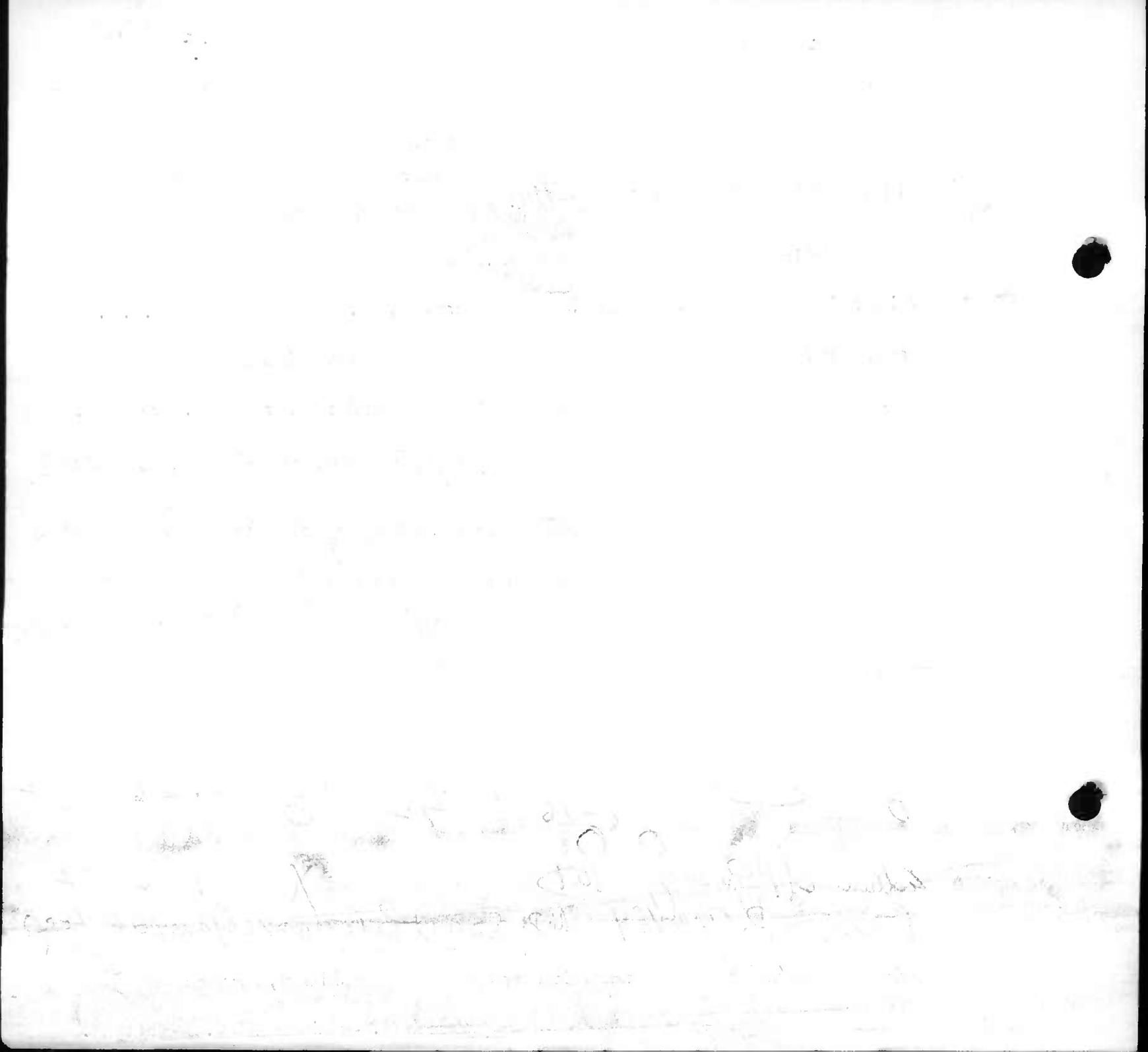
the

the

FUNERAL DIRECTOR: IMPORTANT

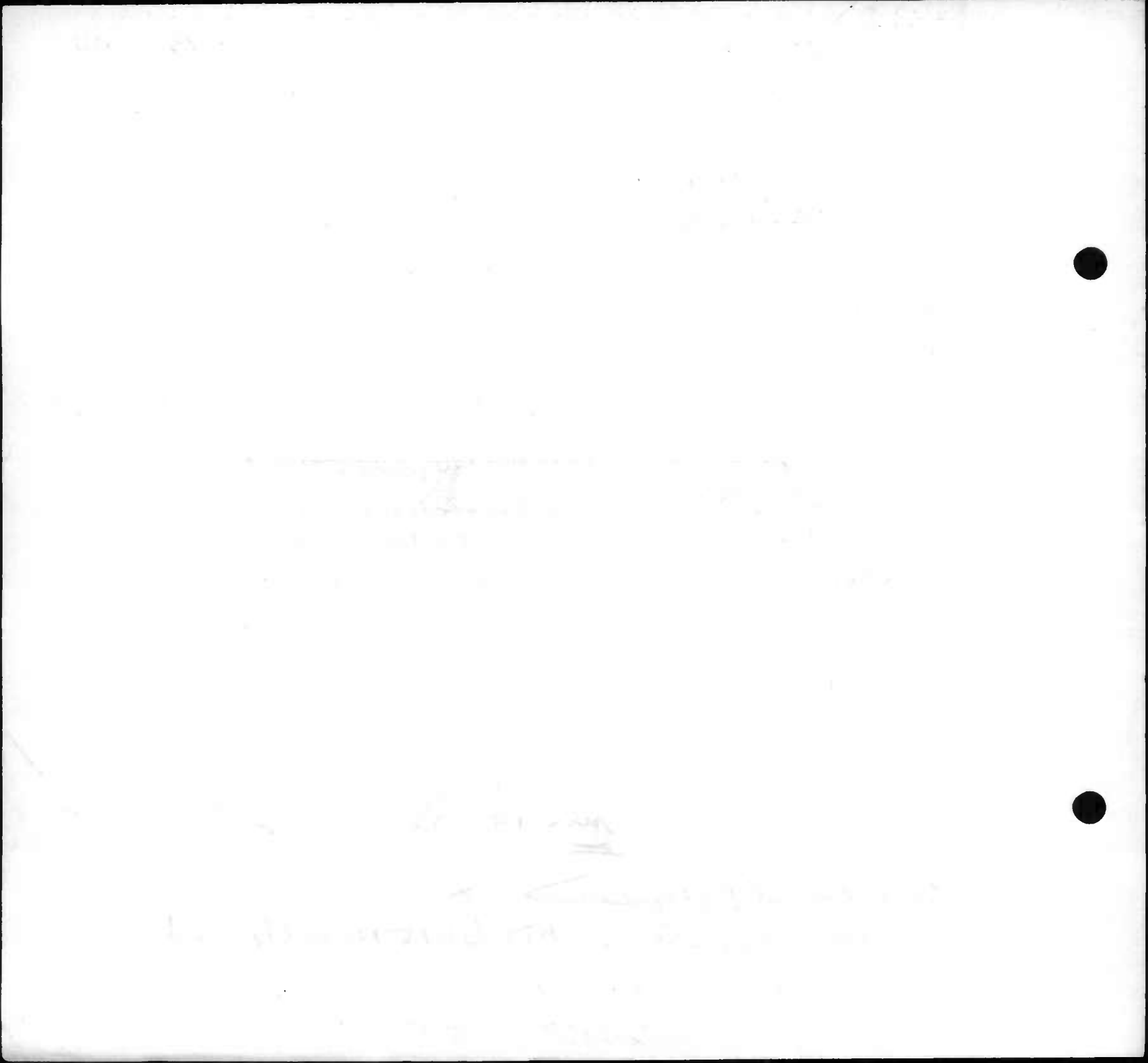
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-460 72 00548		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		X REG. NO. 72 00548	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>FERDINAND KELLER</b>		2. DATE AND HOUR OF DEATH <b>JAN 16 1972 3:15 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b>		5. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>SOUTH BALTIMORE GENERAL HSP</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <b>7608 Avondale Avenue</b>	
5. SEX <b>M</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/29/08</b>	9. AGE (in years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Ship</b>		11. BIRTHPLACE (State or foreign country) <b>Scranton, Pa.</b>	
13. FATHER'S NAME <b>Frank Keller</b>		14. MOTHER'S MAIDEN NAME <b>Helen Weisman</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>213-07-2590</b>		17. INFORMANT <b>Julius Keller - 641 S. Grundy St.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>272X1</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Congestive Heart Failure 9 years</b>			
		(B) <b>ATHEROSCLEROSIS of Coronary Arteries</b> DUE TO, OR AS A CONSEQUENCE OF:			
		(C) <b>SEVERE Obesity</b> DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<b>CHRONIC obstructive Airway disease 10 years</b>			
19A. DATE OF OPERATION <b>None</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) <b>this hospital</b> attended the deceased from <b>1-9</b> 19 <b>72</b> to <b>1-16</b> 19 <b>72</b> that <b>(I)</b> (we) last saw the deceased alive on <b>1-16</b> 19 <b>72</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above <b>(I)</b> (We) <b>did</b> (did not) view the body after death.					
23A. SIGNATURE <b>Edmund P. Garvey M.D.</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1-16-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>EDMUND P. GARVEY M.D.</b>		23D. ADDRESS <b>SOUTH BALTIMORE GENERAL HSP</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/19/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>	
24D. LOCATION <b>Baltimore, Maryland</b>		24E. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>			
25A. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25B. FUNERAL DIRECTOR <b>Joseph N. Zannino</b>		ADDRESS <b>- 263 S. Conkling St.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H-252		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00549	
BIRTH NO. 72 00549		1. NAME OF DECEASED (Type or Print) EVELYN HASKINS		2. DATE AND HOUR OF DEATH January 14, 1972 1:40 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE Maryland B. COUNTY BALTO		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Century Home, Inc. 102 N. Paca St Baltimore, Maryland 21202		5. SEX Female		6. RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 10-25-84		9. AGE (In years last birthday) 87		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Charlotte Court House, Va.	
12. CITIZEN OF WHAT COUNTRY? U.S.A		13. FATHER'S NAME Scott Burrell		14. MOTHER'S MAIDEN NAME Sallie Brown		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Va.	
16. SOCIAL SECURITY NO. 218-26-1955A		17. INFORMANT Mrs. Lelia Taliferro 1802 Moreland Ave. 21217 Mrs. Sallie Robinson 1 Cargil Ave. 21218		18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		ANTECEDENT CAUSES		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) slowing the UNDERLYING CONDITION lost.		DUE TO, OR AS A CONSEQUENCE OF: Cardio Respiratory Failure		DUE TO, OR AS A CONSEQUENCE OF: Atherosclerotic CHD			
		DUE TO, OR AS A CONSEQUENCE OF: Benign Cerebral Arter.		DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus			
		Fractured FEMUR					
19A. DATE OF OPERATION 12-29-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Fx FEMUR		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Nursing Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 102 N. Paca St			
21D. TIME OF INJURY (APPROX.) 12-29-71		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? fall			
22. I certify that (I) (this hospital) attended the deceased from January 13 19 72 to January 14 19 72		that (I) (we) last saw the deceased alive on Jan 14 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.		23A. SIGNATURE Willard Appleford		23B. DATE SIGNED 1-18-72	
23C. PHYSICIAN'S NAME (Type) Willard Appleford		23D. ADDRESS 6615 Rutherford Rd		23E. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-18-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1972		25B. NAME OF REGISTRAR Phil A. E. Taylor, M.D.		25C. FUNERAL DIRECTOR 1735 Hartford Ave. 21205 Marshall W. Jones, Jr.			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-242 72 00550		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00550	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) August Nicklas		2. DATE AND HOUR OF DEATH 1-17-72 7:50 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hospital		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 23 01 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1218 S. Hanover Street			
5. SEX Male	6. RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/7/03	9. AGE (In years last birthday) 68	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Grocery		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Ernest C. Nicklas		14. MOTHER'S MAIDEN NAME Rose Strohmaier	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. unknown		17. INFORMANT ADDRESS Naomi A. Nicklas 1218 S. Hanover Street	
18. 485X I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH ① (R+) Pulver like Bronchopneumonia ② Hypertensive - Atherosclerotic Heart Disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ③ Coronal arteriosclerosis, Chronic brain syndrome (B) DUE TO, OR AS A CONSEQUENCE OF: (C) -----		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <input checked="" type="checkbox"/>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (nearly medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-10-1972 to 1-17-1972 that (I) (we) last saw the deceased alive on 1-17-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Joachim F. Jaeger</i>		DEGREE		23B. DATE SIGNED Jan 17, 1972	
23C. PHYSICIAN'S NAME (Type) DR. JOAQUIM		DEGREE		23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/72		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery	
24D. LOCATION (City, town, or county) Baltimore, Md.		(State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1972		25B. NAME OF REGISTRAR <i>Paul E. Taylor</i>		25C. FUNERAL DIRECTOR ADDRESS McEluffy Funeral Homes 130 E. Fort Ave.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT														
BIRTH NO. 72 00551 72-551					CERTIFICATE OF DEATH					REG. NO. 72 00551 72-551				
1. NAME OF DECEASED (Type or Print) <b>THOMAS B. PERRY</b>					2. DATE AND HOUR OF DEATH <b>1-17-72</b>					M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>908</b>									
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION MEMORIAL HOSPITAL</b>					C. CITY OR TOWN <b>BALTIMORE</b>					D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
E. STREET AND NUMBER <b>2545 GREENMOUNT AVENUE</b>														
5. SEX <b>MALE</b>		6. RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-1-33</b>		9. AGE (In years last birthday) <b>38</b>		10. Under 1 Yr. Months Days		11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANGER</b>					10B. KIND OF BUSINESS OR INDUSTRY <b>BAR</b>					11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>				
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					13. FATHER'S NAME <b>THOMAS PERRY</b>					14. MOTHER'S MAIDEN NAME <b>MANDAR HARRIS</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>					16. SOCIAL SECURITY NO.					17. INFORMANT <b>MARY PERRY 2925 ROCKROSE Ave</b>				
18. <b>25091</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>CARDIAC ARREST-</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ACUTE RENAL FAILURE-</b> DUE TO, OR AS A CONSEQUENCE OF: <b>DIABETES</b> (C)  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
19A. DATE OF OPERATION					19B. CONDITION FOR WHICH OPERATION WAS PERFORMED					20A. AUTOPSY? (Yes or No)				
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?														
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)					21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)					21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)					21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <b>1-11-72</b> to <b>1-17-72</b> that (I) (we) last saw the deceased alive on <b>1-17-72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.														
23A. SIGNATURE <b>Juan M. Caldero</b>					23B. DATE SIGNED <b>1-17-72</b>									
23C. PHYSICIAN'S NAME (Type) <b>JUAN H. CALDERO M.D.</b>					23D. ADDRESS <b>UHH</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>					24B. DATE <b>1-21-72</b>					24C. NAME OF CEMETERY OR CREMATORY <b>ARABIAN MEM. PK.</b>				
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE Co. MD.</b>														
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>					25B. NAME OF REGISTRAR <b>W. H. HARRIS</b>					25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME</b>				
ADDRESS <b>3035 W. NORTH AVE.</b>														



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

M-200 72 00552		BALTIMORE CITY HEALTH DEPARTMENT		72 00552	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>William Mack</b>			2. DATE AND HOUR OF DEATH <b>1/15/72 - 8 PM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>LUTHERAN HOSPITAL OF MARYLAND</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1608</b>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>710 N. HILTON ST.</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-1-1912</b>	9. AGE (In years, lost birthday) <b>69</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cement Finisher</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Carter's Construction</b>		11. BIRTHPLACE (State or foreign country) <b>Virginia</b>	
13. FATHER'S NAME <b>Charles Mack</b>		14. MOTHER'S MAIDEN NAME <b>Mary ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-03-5202</b>		17. INFORMANT <b>Lillian E. Mack</b> ADDRESS <b>710 N. Hilton St.</b>	
18. <b>4369 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CARDIAC ARREST</b> DUE TO, OR AS A CONSEQUENCE OF:  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CEREBRO VASCULAR ACCIDENT</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>CATECHETIC; PROBABLE MYOCARDIAL INFARCTION</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/12/72</b> 19 <b>72</b> to <b>1/15/72</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/15/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Gandoy</b>			23B. DATE SIGNED <b>1/16/72</b>		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
<b>Burial</b>		<b>1-20-72</b>		<b>Arbutus Memorial Park</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>E. J. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>NOTTER FUNERAL HOME</b>	
				ADDRESS <b>3035 W. NORTH AVE.</b>	

100 - 35

100 - 35

100 - 35

100 - 35

100 - 35

100 - 35

100 - 35

100 - 35

100 - 35

100 - 35

100 - 35

100 - 35

100 - 35

100 - 35

100 - 35

100 - 35

100 - 35

100 - 35

100 - 35

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B653 72 00553 BIRTH NO. 68-00584		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 72 00553	
1. NAME OF DECEASED (Type or Print) <b>Sean Bryant</b>			2. DATE AND HOUR OF DEATH <b>1/13/72 18:45 P M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University of Maryland 38 Hospital</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1537</b>		
5. SEX <b>Male</b>			6. RACE <b>Black</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Child</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>1/10/68</b>	9. AGE (In years lost birthday) <b>4</b>
13. FATHER'S NAME <b>Lawrence Bryant Sr.</b>			14. MOTHER'S MAIDEN NAME <b>McNeil, Cynthia</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>LAWRENCE P. BRYANT SR. 3116 Gwynns Falls</b>	
18. <b>486X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Aspiration pneumonia 9 hrs.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>hemolytic uremic syndrome 15 day</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>12/30/71</b> to <b>1/13/72</b> and that <b>(1)</b> (we) lost saw the deceased alive on <b>1/13/72</b> and that <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(1)</b> (We) (did) <del>(did not)</del> view the body after death.					
23A. SIGNATURE <b>Margan Chang M.D.</b>				23B. DATE SIGNED <b>1/13/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARGAN CHANG M.D.</b>				23D. ADDRESS <b>Univ. Hosp.</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-18-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION <b>Baltimore</b>		24E. (City, town, or county)		24F. (State) <b>Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>John E. ...</b>		25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</b>	





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-250		BALTIMORE CITY HEALTH DEPARTMENT		72 00554	
72 00554		CERTIFICATE OF DEATH		REG. NO. 72 00554	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Jackson - John W.		1-16-72		1:15 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
Bolton Hill Nursing Home		MD		BALTO	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		6120 Balto. Nat. Pike			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. CITIZEN OF WHAT COUNTRY?
MALE	NEGRO	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	7-17-89	82	USA
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
caretaker		Black & Decker		Maryland	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Victory Jackson		Mary Susan Veney			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		212-32-2812		Mrs. Beulah H. Jackson 6120 Balto. Nat.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		year	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		year	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:		years	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)	21E. INJURY OCCURRED	21F. HOW DID INJURY OCCUR?			
	While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				
22. I certify that (I) (this hospital) attended the deceased from 12/31/1971 to 1/16/1972 that (I) (we) lost saw the deceased alive on 1/16/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
[Signature]		1/17/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
ALAN H. MARCH MD		2 E READ ST		BALTIMORE	
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME OF CEMETERY OR CREMATORY	24D. LOCATION	(City, town, or county) (State)	
Burial	1-20-72	Mt. Auburn Cemetery	Baltimore	Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 18 1972		[Signature]		NUTTER FUNERAL HOME 3035 W. NORTH	

170 52

170 52

170 52

170 52

170 52

170 52

170 52

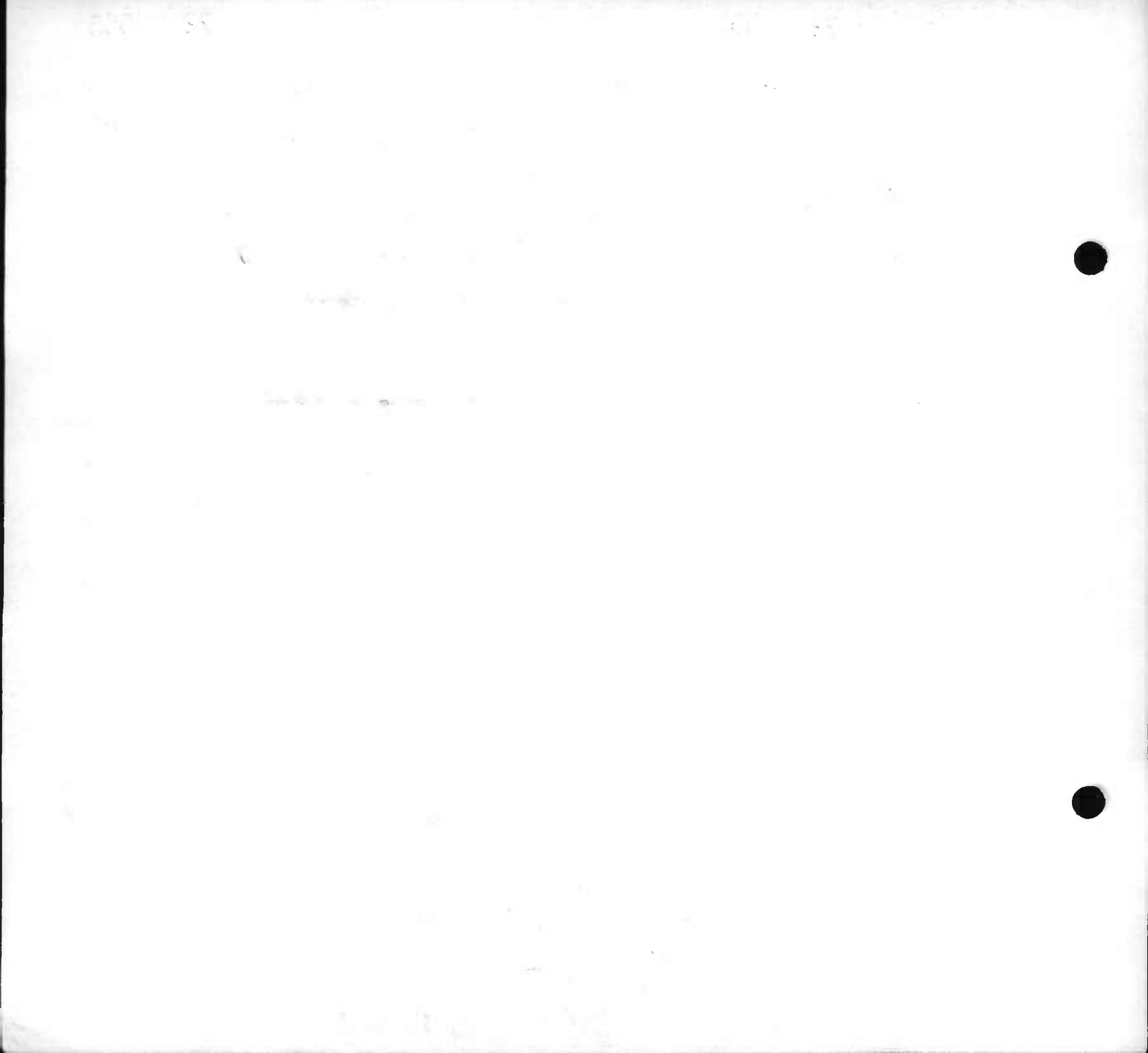
170 52

170 52

170 52

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-350 72 00555		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00555	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) CLIFTON TATUM		2. DATE AND HOUR OF DEATH 1/15/72 7:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY 1607			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1630 N. HILTON ST. APT A BALTO. MD. 21216		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE		6. RACE NEGRO		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EDUCATION SPECIALIST		10B. KIND OF BUSINESS OR INDUSTRY U.S. GOV'T		8. DATE OF BIRTH 7/30/24	
13. FATHER'S NAME CLIF TATUM		14. MOTHER'S MAIDEN NAME SOPHIA JENKINS		9. AGE (In years last birthday) 47	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) YES		16. SOCIAL SECURITY NO. 461-26-7218		17. INFORMANT ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Severe Hypertensive Cardiovascular Disease	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		possible CVA or cardiac arrhythmia	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)			
19A. DATE OF OPERATION NONE		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED NONE		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7/13 1970 to 1/15 1972 that (I) (we) last saw the deceased alive on 12/21 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE ELIJAH SAUNDERS, M.D.		23B. DATE SIGNED 1/17/72		23C. PHYSICIAN'S NAME (Type) ELIJAH SAUNDERS, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-20-72		24C. NAME OF CEMETERY OR CREMATORY ARBUTUS MEMORIAL PARK	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS NUTTER FUNERAL HOME 3035 W. NORTH AVE.	
24D. LOCATION (City, town, or county) BALTIMORE CO., MARYLAND		24E. STATE (State) MARYLAND			



72 00556 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00556

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>William J. N. Turks</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>38 UNIVERSITY HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour M. <b>January 14, 1972 8:05 P.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1538</b>	
9. DATE OF BIRTH <b>2-1-1910</b>		10. AGE (In years last birthday) <b>61</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Shadrock Turks</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Assistant Manager Mutual of Balto.</b>	
15. MOTHER'S MAIDEN NAME <b>Anastatia Brown</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes World War II</b>	
17. SOCIAL SECURITY NO. <b>212-07-4820</b>		18. INFORMANT <b>Mrs. Louise G. Turks</b>	
19. CAUSE OF DEATH <b>Multiple Injuries</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C)	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID INJURY OCCUR? <b>2900 Garrison Blvd. S. of Grantley Street</b>		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>1-14-72 5:45 P.m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Pedestrian struck by car</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> DATE SIGNED <b>1/15/72</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-19-1972</b>	
24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Co. Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. [illegible]</b>	
25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME</b>		ADDRESS <b>3035 W. NORTH AV</b>	

UNITED STATES OF AMERICA

DEPARTMENT OF JUSTICE

WASHINGTON, D.C.

RECEIVED

1950

1950

ALL INFORMATION CONTAINED

HEREIN IS UNCLASSIFIED

DATE 10-10-1980

BY SP-10/10

EXCEPT WHERE SHOWN

OTHERWISE, IT IS THE POLICY

OF THE NATIONAL ARCHIVES

TO MAKE THIS INFORMATION

AVAILABLE TO THE PUBLIC

UNLESS IT DETERMINES

THAT RELEASE OF THE

RECORD

*[Handwritten signature]*

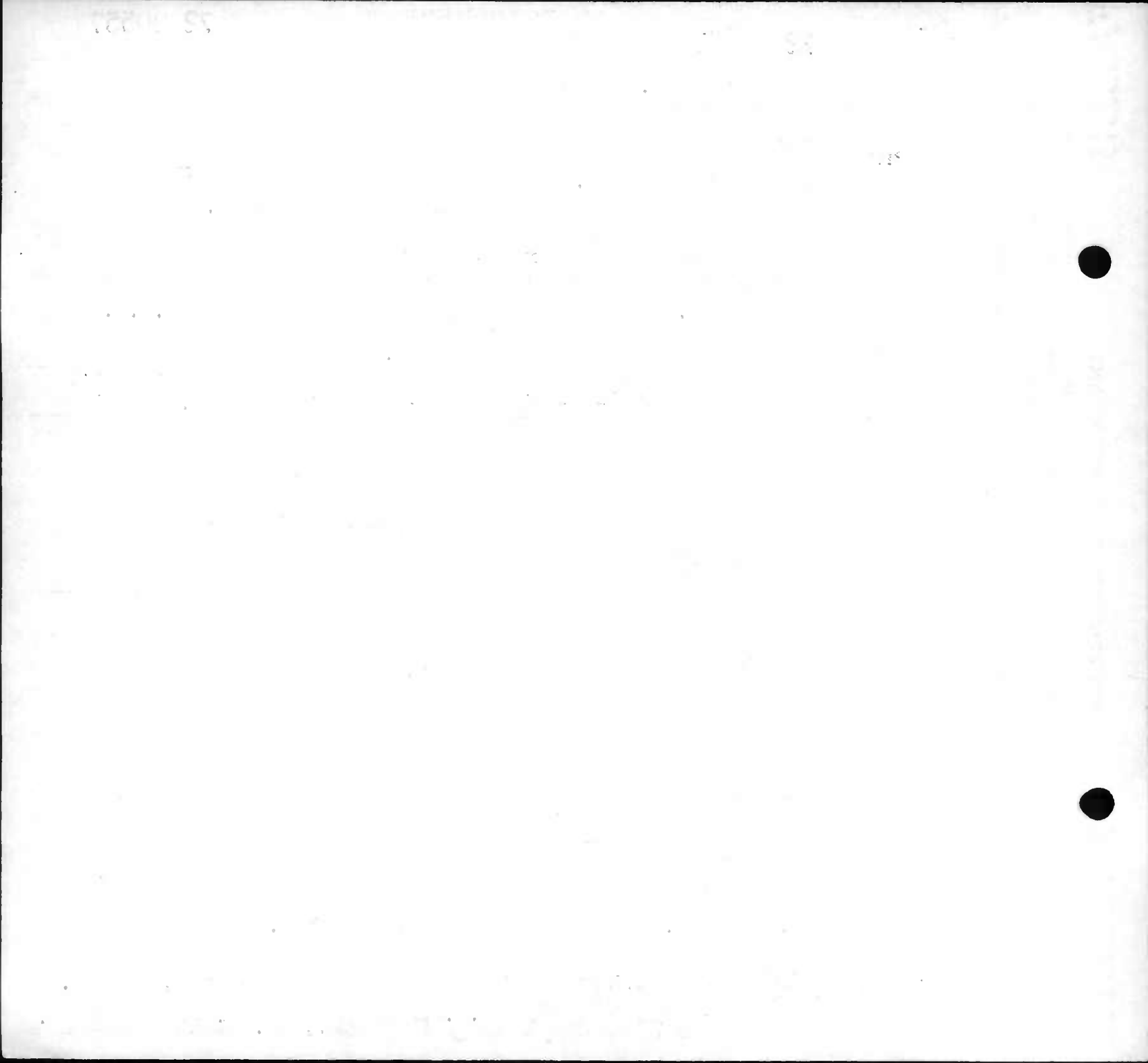
1-10-1977

1-10-1977

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<h2 style="margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</h2> <h3 style="margin: 0;">CERTIFICATE OF DEATH</h3>		REG. NO. <span style="font-size: 1.2em;">72 00557</span>	
BIRTH NO. <span style="font-size: 1.2em;">H-652 72 00557</span>			
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Robert A. Hering</span>		2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">1/14/1972 11 P. M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.1em;">5711 Chinguapin Pkwy.</span>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.1em;">Maryland</span> B. COUNTY <span style="font-size: 1.1em;">2748</span> C. CITY OR TOWN <span style="font-size: 1.1em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.1em;">5711 Chinguapin Pkwy.</span>	
5. SEX <span style="font-size: 1.1em;">M</span>	6. RACE <span style="font-size: 1.1em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.1em;">4/4/1911</span>
9. AGE (In years last birthday) <span style="font-size: 1.1em;">60</span>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Auditor</span>	11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">Maryland</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">U.S.A.</span>		13. FATHER'S NAME <span style="font-size: 1.1em;">Fritz Hering</span>	
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Eva E. Hampton</span>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">Yes WWII</span>	
16. SOCIAL SECURITY NO. <span style="font-size: 1.1em;">218-07-7811</span>		17. INFORMANT ADDRESS <span style="font-size: 1.1em;">Frederick Hering, 222 St. Paul Place 21202</span>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <div style="text-align: center; font-weight: bold;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.1em;">myocardial infarction 1 day</span> <span style="font-size: 1.1em;">Coronary A.S. 4 years</span>	
19A. DATE OF OPERATION <span style="font-size: 1.1em;">0</span>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.1em;">No</span>	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <span style="font-size: 1.1em;">No</span>		20B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <span style="font-size: 1.1em;">No</span>	
21A. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <span style="font-size: 1.1em;">No</span>		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <span style="font-size: 1.1em;">No</span>	
21C. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21D. HOW DID INJURY OCCUR? <span style="font-size: 1.1em;">No</span>	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.1em;">Jan 1967</span> to <span style="font-size: 1.1em;">Jan 14, 1972</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.1em;">Dec 27, 1970</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.			
23A. SIGNATURE <span style="font-size: 1.1em;">Dr. Lewis A. Kolodny</span>		23B. DATE SIGNED <span style="font-size: 1.1em;">1/17/72</span>	
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">Dr. Lewis A. Kolodny</span>		23D. ADDRESS <span style="font-size: 1.1em;">1825 Eastern Blvd.</span>	
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>		24B. DATE <span style="font-size: 1.1em;">1/18/72</span>	
24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.1em;">Woodlawn</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Baltimore County, Md.</span>	
25A. DATE RECEIVED BY HEALTH DEPT. <span style="font-size: 1.1em;">JAN 18 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.1em;">H.W. Jenkins &amp; Sons Co.</span>	
25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.1em;">4905 York Rd. Baltimore, Md. 21212</span>			

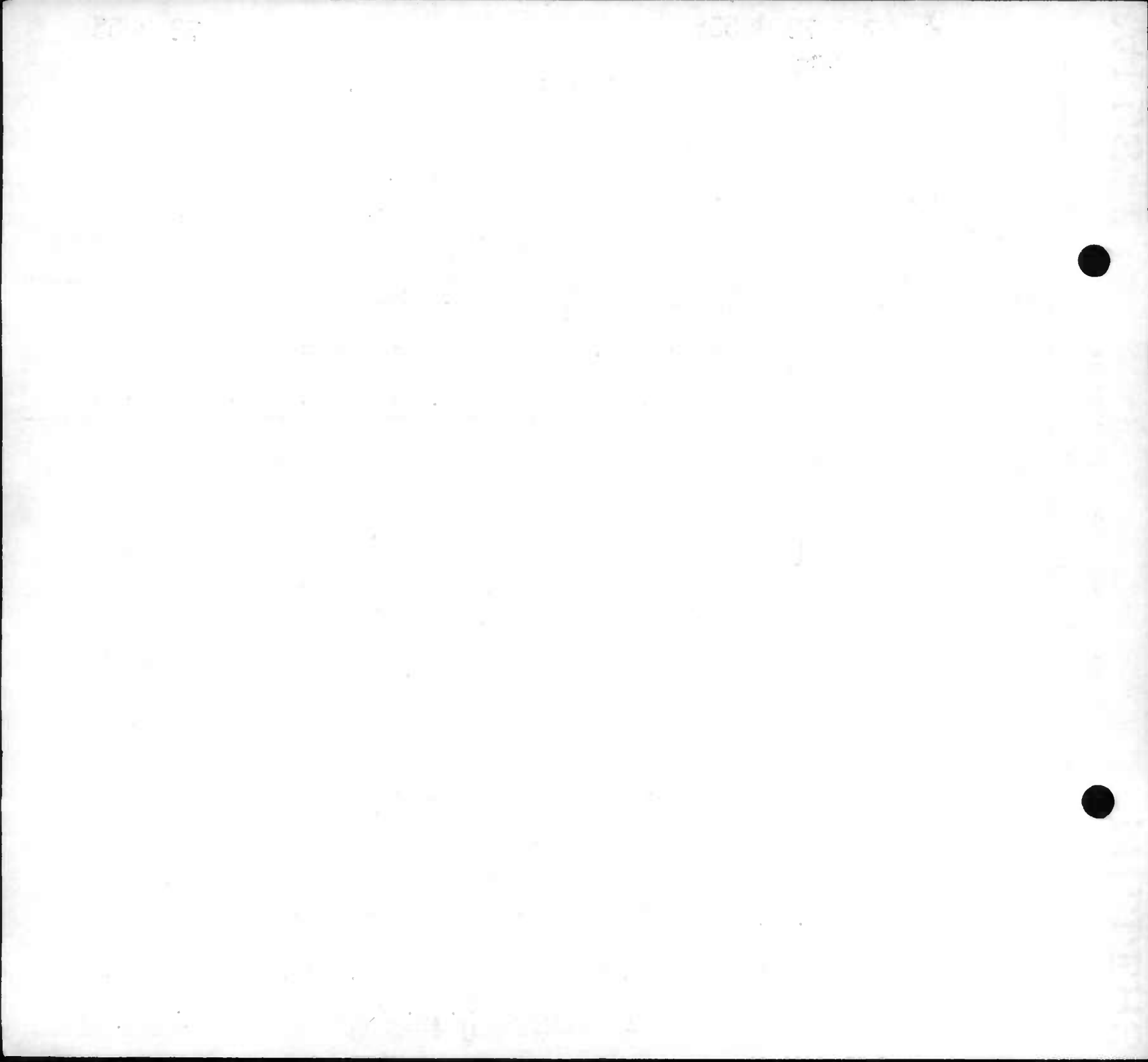




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

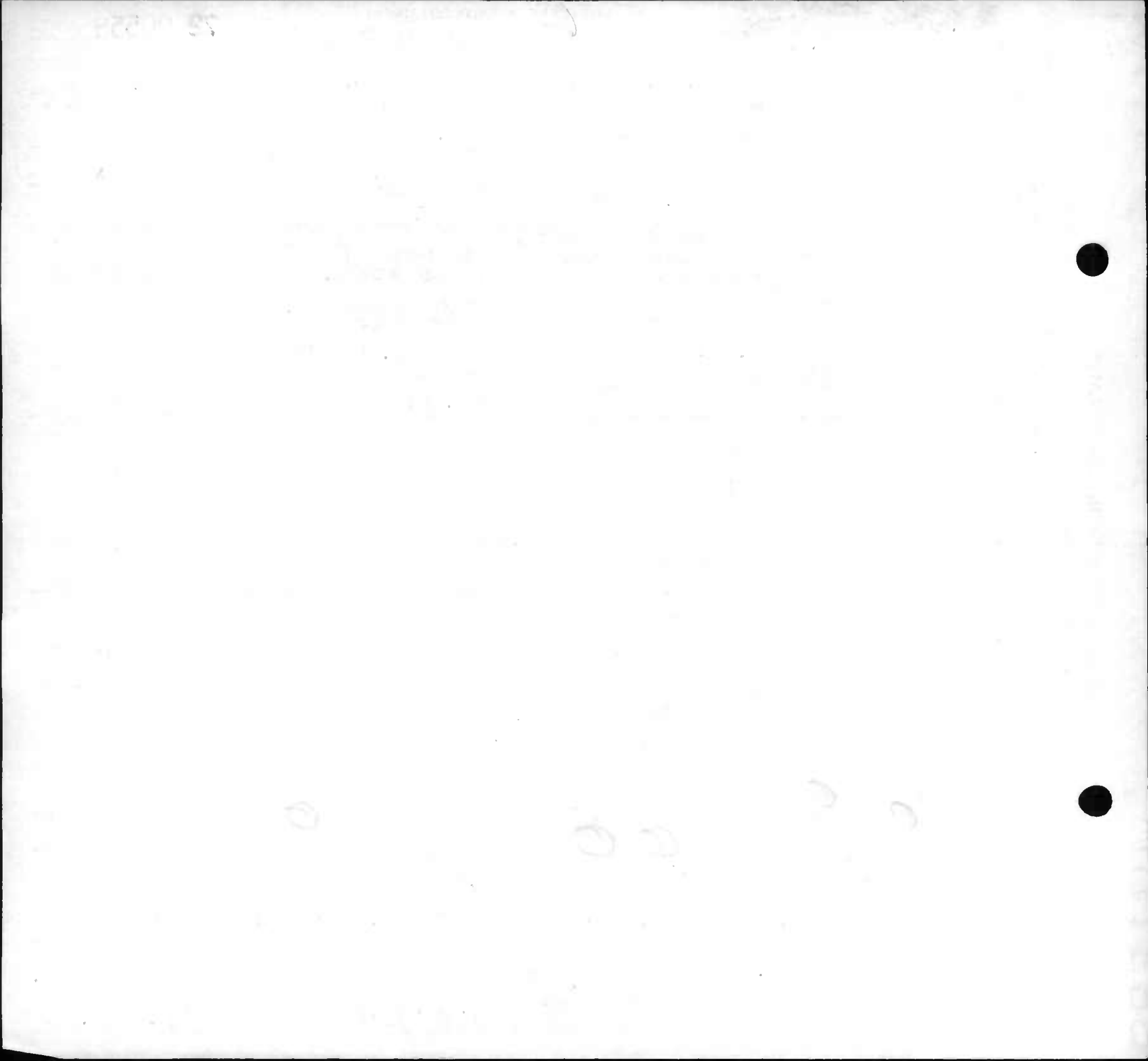
D-325 72 00558		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00558	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)		Henry Clay Dodson, III		2. DATE AND HOUR OF DEATH Jan. 17, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		PA. M.	
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY	
00 Pentridge Apts.				Maryland	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER		1502 Pentridge Road 21212	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
M	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	3-7-1901	70	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Ret'd. Insurance Executive		Life American Health &		St. Michaels, Maryland	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
USA		Henry Clay Dodson, Jr.		Estelle Watts	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
No		223-03-2790		Mrs. Miriam P. Dodson	
				ADDRESS	
				Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Myocardial Infarction		Immediate	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
		Arteriosclerotic cardiac vascular disease		5 yrs.	
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) _____			
II		Diabetes mellitus		2 yrs.	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from January 1970 to January 17, 1971 that (I) (we) last saw the deceased alive on January 4, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Dr. A. Allan Spier		1/17/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Dr. A. Allan Spier		1501 Pentridge Road			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/19/72		Olivet	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR		24F. FUNERAL DIRECTOR	
St. Michael's, Md.		JAN 18 1972		H. W. Jenkins & Sons Co.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		ADDRESS	
JAN 18 1972		H. W. Jenkins & Sons Co.		4905 York Road Balto., Md. 21212	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 00559</span>	
<div style="display: flex; justify-content: space-between;"> <span># 525 72-559</span> <span style="font-size: 1.2em;">BIRTH NO.</span> </div>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.1em;">Lucy E. B. Hynson</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.1em;">Jan. 18, 1972</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.2em;">90 Long Green Nursing Home</span>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <span style="font-size: 1.1em;">Pa.</span> B. COUNTY <span style="font-size: 1.2em;">V 35</span>		
5. SEX <span style="font-size: 1.1em;">F</span>		6. RACE <span style="font-size: 1.1em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <span style="font-size: 1.1em;">3-29-1879</span>
9. AGE (In years last birthday) <span style="font-size: 1.1em;">92</span>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Housewife</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.1em;">Philadelphia, Pa.</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.1em;">USA</span>		13. FATHER'S NAME <span style="font-size: 1.1em;">George B. Bains</span>		14. MOTHER'S MAIDEN NAME <span style="font-size: 1.1em;">Lucy D. Erskine</span>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">No</span>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <span style="font-size: 1.1em;">Mr. Richard Hynson 105 Elmhurst Road</span>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">ASCVD</span> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		
19. DATE OF OPERATION			19A. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (1) (this hospital) attended the deceased from <span style="font-size: 1.1em;">7/27/66</span> 19 to <span style="font-size: 1.1em;">1/18/72</span> 19 that (2) (we) last saw the deceased alive on <span style="font-size: 1.1em;">1/8/72</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.2em;">Francis W. Gluck</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">1/18/72</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.1em;">Dr. Francis W. Gluck</span>			23D. ADDRESS <span style="font-size: 1.1em;">100 W. University Parkway</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.1em;">Burial</span>		24B. DATE <span style="font-size: 1.1em;">11-20-72</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.1em;">Greenmount</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.1em;">Baltimore, Md.</span>		25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 18 1972</span>			
25B. NAME OF REGULAR FUNERAL DIRECTOR <span style="font-size: 1.2em;">H. W. Jenkins &amp; Sons Co.</span>				25C. ADDRESS <span style="font-size: 1.1em;">4905 York Road Balto., Md. 21212</span>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-320		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00560	
72 00560		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Margaret Watkins		2. DATE AND HOUR OF DEATH 1-17-72 10:48 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1502			
FULL NAME OF HOSPITAL OR INSTITUTION 37 Mercy Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1805 N. Fulton Ave			
5. SEX Female	6. RACE C	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2-22-1908 67	9. AGE (In years last birthday)
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Wilson N.C.	12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME JESSE BARNES		14. MOTHER'S MAIDEN NAME BARNES			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT Alma Barnes 1805 N. Fulton Ave	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) 4-10-9 I		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarct		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr.	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) ASCVD, atherosclerosis		Y-5.	
(C)					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) Y-3	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-16-1972 to 1-17-1972 that (I) (we) last saw the deceased alive on 1-17-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE M. V. EDELSTEIN, M.D.		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1/17/72	
23C. PHYSICIAN'S NAME (Type) M. V. Edelstein		23D. ADDRESS MERCY HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-22-72		24C. NAME OF CEMETERY or CREMATORY Baltimore Nat. Park	
24D. LOCATION (City, town, or county) (State) Howard County					
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1972		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Margaret R. Brown 316 Walkbrook	

100



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-520 72 00561		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 72 00561	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Thomas, Clarence</b>		2. DATE AND HOUR OF DEATH <b>1/13/72 9:00 a.m.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1547</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>George Washington Nursing Home 607 Pennsylvania Avenue Baltimore, Maryland 21201</b>		C. CITY OR TOWN <b>Baltimore</b>		E. STREET AND NUMBER <b>3108 Windsor Avenue</b>	
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/17/86</b>	9. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>United States</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Unknown</b>		16. SOCIAL SECURITY NO. <b>705-05-8435</b>		17. INFORMANT <b>Geraldine Brown</b> <b>Chart 3108 Windsor</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CEREBRAL APOPLEXY</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>HYPERTENSION</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ARTERIOSCLEROSIS</b>		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) 1 (Month) 1 (Day) 1 (Year) 1 (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>1-6-72</b> 19 <b>72</b> to <b>1-13-72</b> 19 <b>72</b> that (1) (we) last saw the deceased alive on <b>1-9-72</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard F. Tyson, M.D.</b>		23B. DATE SIGNED <b>1-13-72</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Richard F. Tyson M.D.</b>	
23D. ADDRESS <b>936 West North Avenue Baltimore, Maryland 21217</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-17-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>mt zion</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto, County</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Margaretta Robinson Brown</b> <b>3106 Walbrook</b>	

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914

1914



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620 72 00562		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00562	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) JOHN BROOKS,		2. DATE AND HOUR OF DEATH 1-17-72 8:45 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY 843			
FULL NAME OF HOSPITAL OR INSTITUTION 33 THE JOHNS HOPKINS HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 1426 N. POTOMAC ST.			
5. SEX MALE	6. RACE NEGRO	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-1-07	9. AGE (In years last birthday) 64	10. Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Heel Worker		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) S. Carolina	
12. CITIZEN OF WHAT COUNTRY? U. S. A.		13. FATHER'S NAME James (JIM) BROOKS		14. MOTHER'S MAIDEN NAME MINNIE (BOYD) Kirby	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Lellie Mae Brooks - 1426 N. Potomac St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) myocardial infarction		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: HASCUD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). hypertensive renal disease					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) no	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/16 19 72 to 1/17 19 72 that (I) (we) last saw the deceased alive on 1/17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Penelope Scott		23B. DATE SIGNED 1/17/71			
23C. PHYSICIAN'S NAME (Type) PENELOPE SCOTT		23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 1-21-72		24C. NAME OF CEMETERY or CREMATORY Shinnabro, S. Carolina	
24D. LOCATION (City, town, or county) (State)		24E. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR Morton B. Clickson - 11297 Caroline St.	
25A. DATE REC'D BY HEALTH DEPT. JAN 18 1972		25B. NAME OF REGISTRAR			

.T. CHAT.

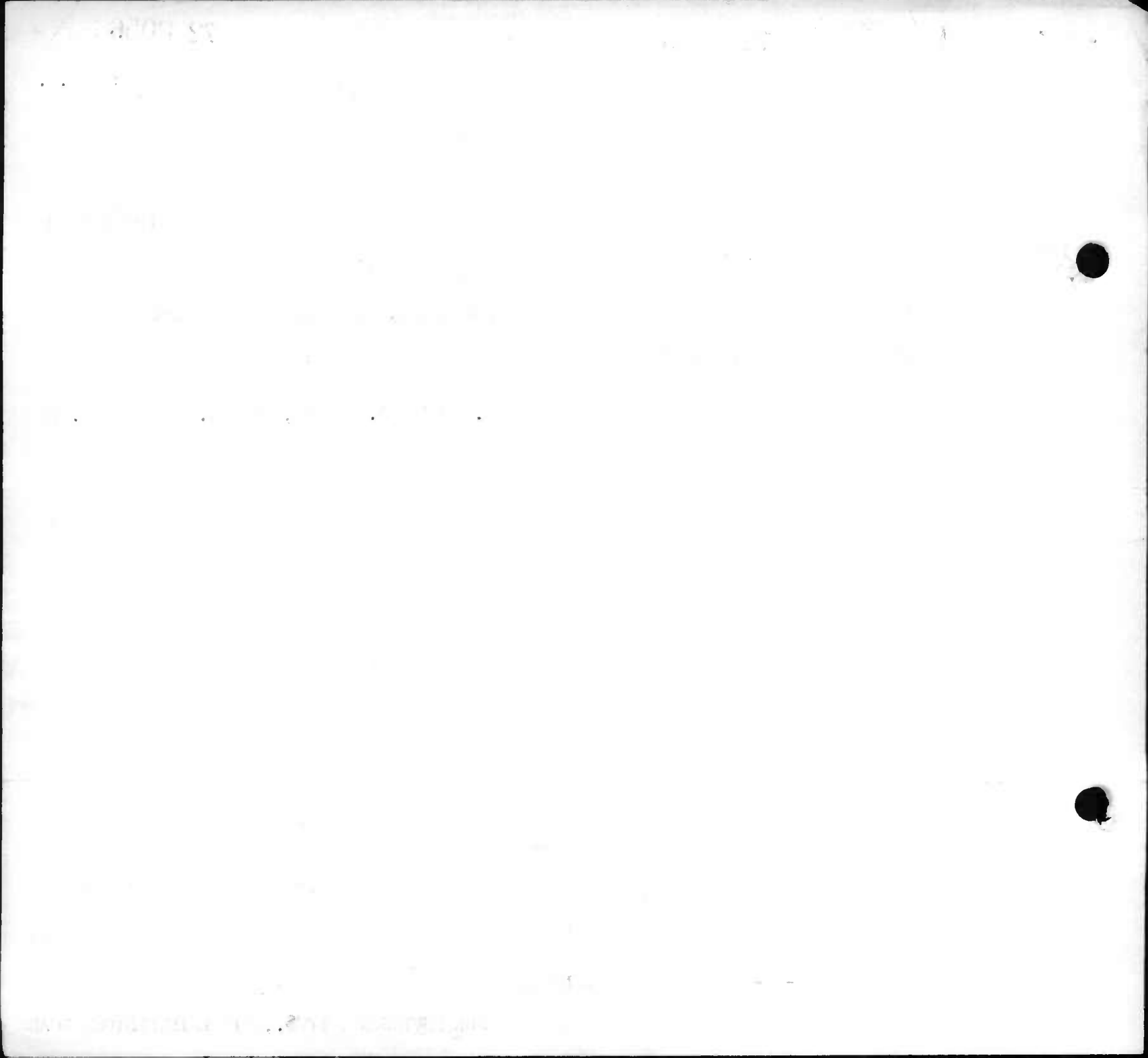
BY BILL

ON

HI

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-355		72 00563		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00563	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		12:05 A.M.	
		DORA GUTMAN		JAN. 16, 1972		00:05 A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 42 SINAI HOSPITAL BALTIMORE				A. STATE MD. B. COUNTY BALTIMORE 2720			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER 7014 PARK HEIGHTS AVE # 2125			
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 12/17/XX4X03	9. AGE (In years last birthday) 68	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME X SAFFRON				14. MOTHER'S MAIDEN NAME TILLIE ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO.		17. INFORMANT MR. EDWARD J. GUTMAN, 2306 W. ROGERS AVE. #9			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 410.71 VENTRICULAR ARRHYTHMIA (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE MYOCARDIAL INFARCTION (B) DUE TO, OR AS A CONSEQUENCE OF: ARTERIOSCLEROTIC CARDIOVASC. DISEASE (C)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (if this hospital) attended the deceased from 12/30 1971 to 1/16 1972 that (if we) last saw the deceased alive on 1/15 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (if We) (did not) view the body after death.							
23A. SIGNATURE Armando C. DiJanco, Jr. M.D.				23B. DATE SIGNED Jan. 16, 1972			
23C. PHYSICIAN'S NAME (Type) ARMANDO C. DIJANCO, M.D.				23D. ADDRESS Sinai Hospital Baltimore, Ind.			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-17-72		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW		24D. LOCATION (City, town, or county) (State) BALTIMORE, MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS.		ADDRESS 6010 REISTERSTOWN ROAD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

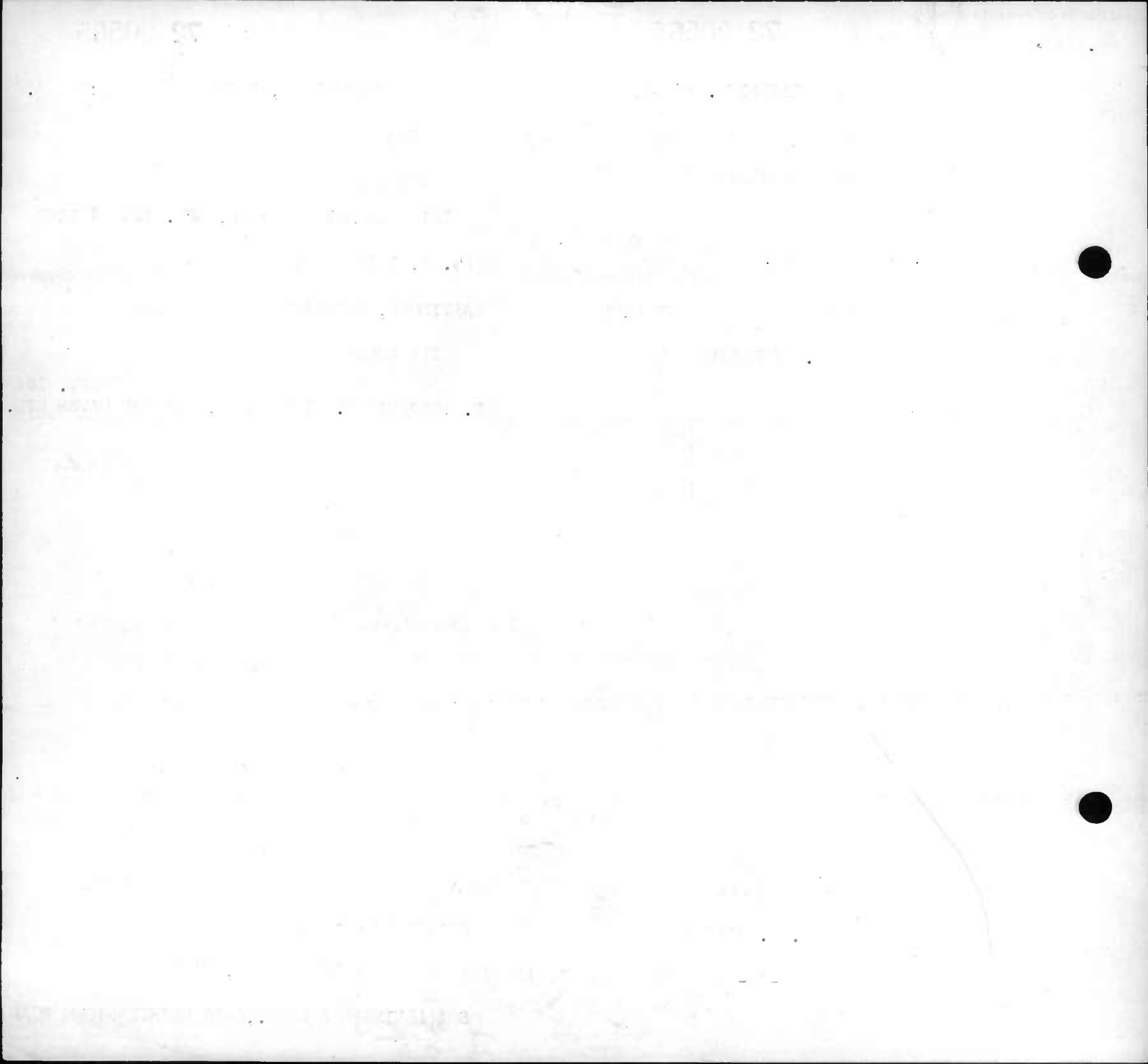
7-524 72 00564		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		72 00564 REG. NO.	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		FINKELESTEIN, IDA		1/14/72 4 <sup>15</sup> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		MARYLAND		2740	
42 Sinai Hospital of Baltimore		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 3010 Glena Ave. #15			
5. SEX Female	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JUNE 3, 1884	9. AGE (In years last birthday) 87	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY AT HOME	11. BIRTHPLACE (State or foreign country) RUSSIA		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME AARON GERBER			14. MOTHER'S MAIDEN NAME ETTE ?		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-07-5750D		17. INFORMANT MRS. ROSE RUBIN, 3010 GLEN AVENUE #21215	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not include the mode of dying, e.g., heart failure, asphyxia, etc., if these are disease, injury or complication which caused death) Diabetes Mellitus		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus & ASCVD		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes Mellitus & ASCVD		(C) <del>Coronary Arteriosclerotic Cardiovascular Disease</del>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 1-14-1972		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Decubitus Wound - Infected		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12/22/71 to 1/14/72 that (I) (we) last saw the deceased alive on 1/14/72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE H. LEVERUE				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) [Signature]				23D. ADDRESS	
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-16-72		24C. NAME of CEMETERY or CREMATORY BOBROISKER BENEFICIAL CIRCLE	
24D. LOCATION ROSEDALE, MARYLAND		24E. CITY, town, or county BALTIMORE		24F. STATE MARYLAND	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1972		25B. NAME OF REGISTRAR [Signature]		25C. FUNERAL DIRECTOR SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

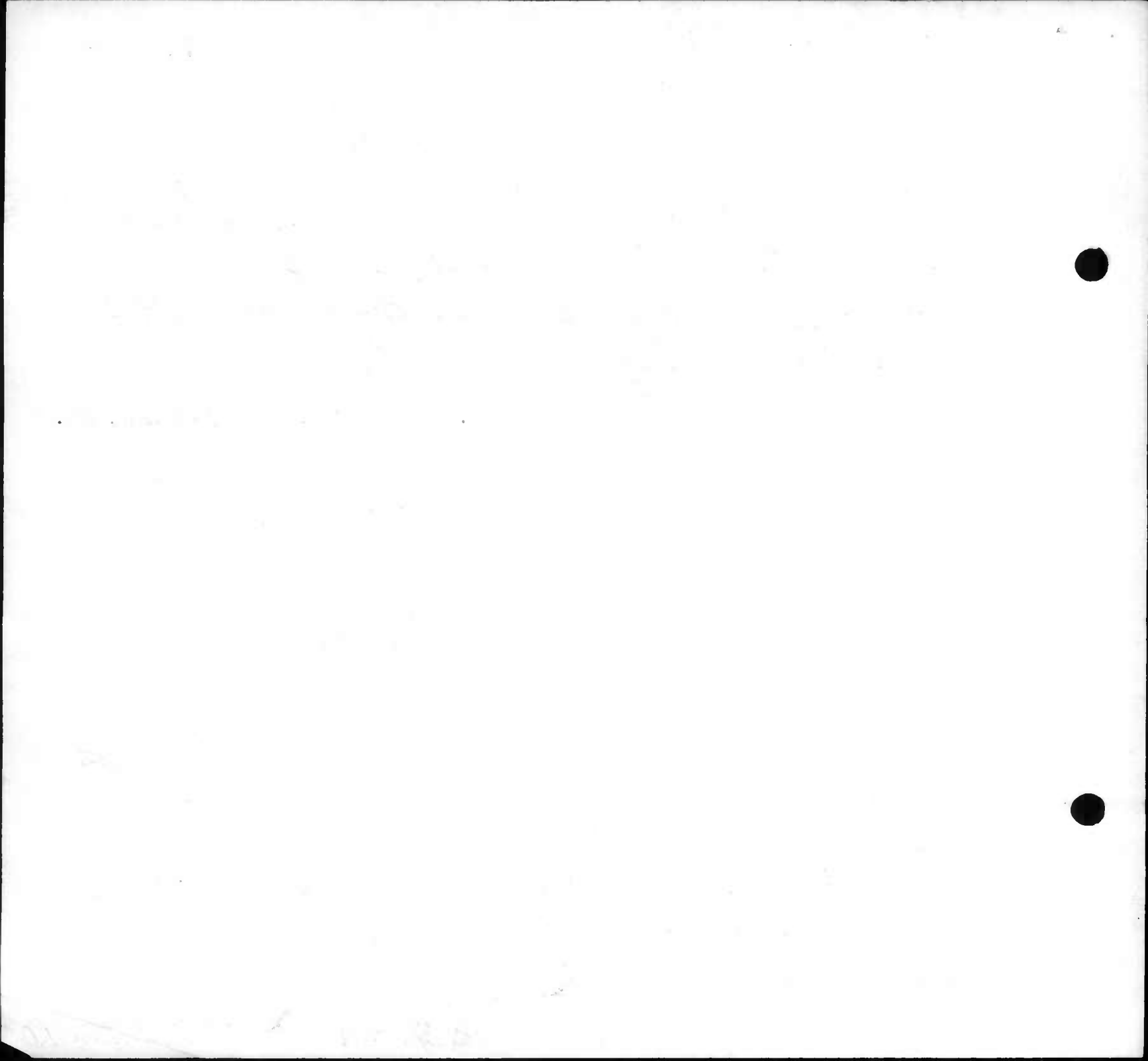
BIRTH NO. <b>M-242</b>		72 00565		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00565</b>	
1. NAME OF DECEASED (Type or Print) <b>RACHAEL REXDUX G. MICHAELSON</b>				2. DATE AND HOUR OF DEATH <b>JANUARY 15, 1972 6:30 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>42 SINAI HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>7214 OAK HAVEN CIRCLE, APT. 204 #21207</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>SEPT. 2, 1925</b>	9. AGE (In years last birthday) <b>46</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>		
13. FATHER'S NAME <b>MORDECIA M. GARONZIK</b>			14. MOTHER'S MAIDEN NAME <b>IDA RODER</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>			16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. BENJAMIN R. MICHAELSON</b>		
					ADDRESS <b>APT. 204 7214 OAK HAVEN CIR.</b>		
18. <b>710.9 14250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>myocardial infarct 9-16-70</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Nichols Mellets</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>18 years</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>Aug. 7 1959</b> to <b>Jan. 15 1972</b> , that (I) (we) last saw the deceased alive on <b>Jan. 3 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>A. A. Silver</b>				23B. DATE SIGNED <b>1-15-72</b>		23C. PHYSICIAN'S NAME (Type) <b>A. A. SILVER</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>1-16-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>CHEB SHALOM MEMORIAL PARK</b>	
24D. LOCATION (City, town, or county) (State) <b>REISTERSTOWN, MARYLAND</b>				25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor, R.D.</b>				25C. FUNERAL DIRECTOR <b>BOB LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			





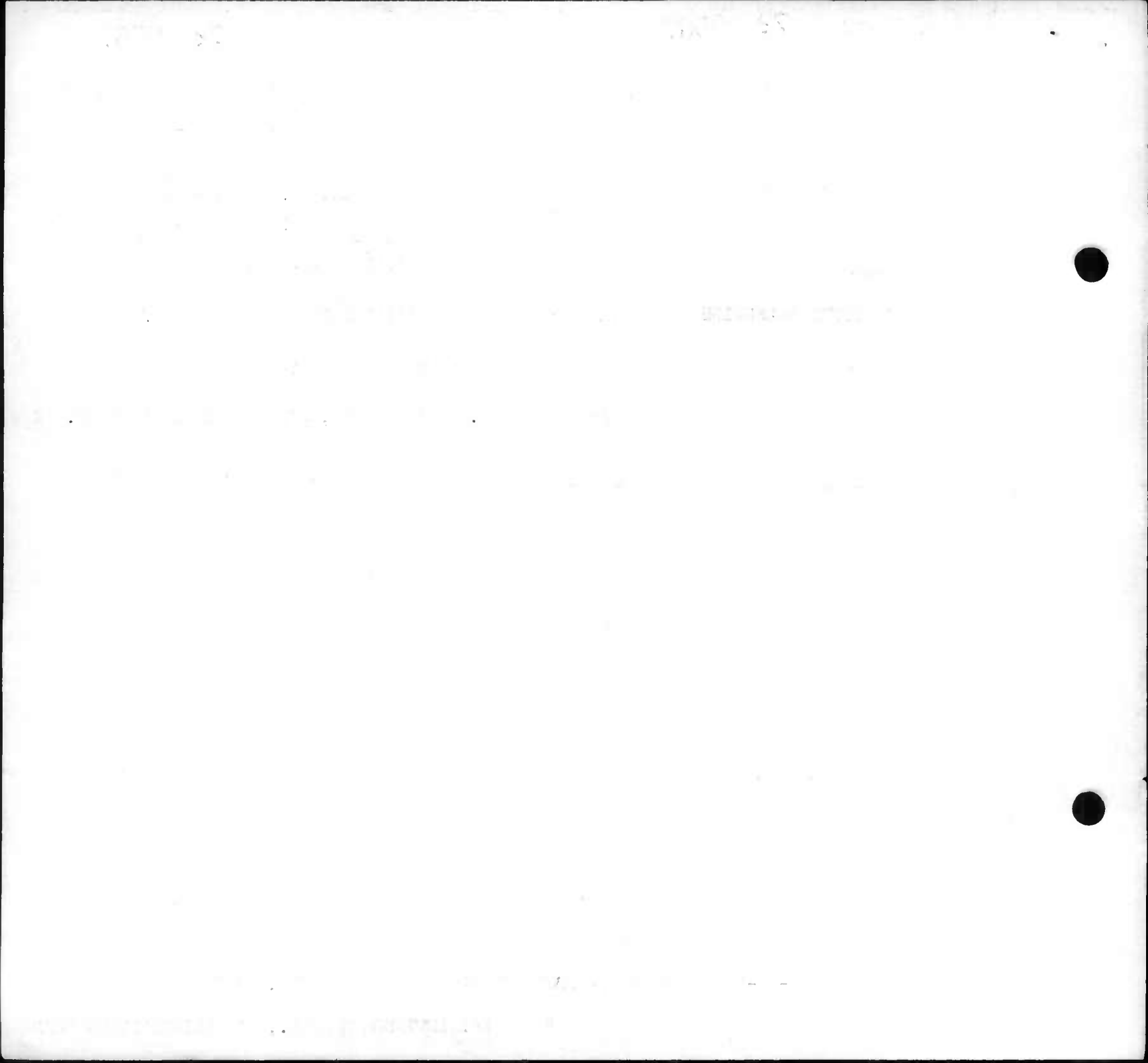
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-626 72 00566		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00566	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>BERGER, MARYL</b>		2. DATE AND HOUR OF DEATH <b>1/16/72 at 9-20 AM</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2720</b>		M.	
FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore General Hospital</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>4300 Brookhill Rd. 21415</b>					
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/23/13</b>	9. AGE (In years last birthday) <b>58</b>	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Israel Kurovsky</b>		14. MOTHER'S MAIDEN NAME <b>Rachel ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. JOSEPH HIRSCH, 3332 CLARKS LANE, APT. D</b>	
18. <b>68291</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTecedent CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <b>Bacteremia secondary to an abscess</b> DUE TO, OR AS A CONSEQUENCE OF: <b>undetermined site. Bacteremia secondary to a granuloma caused by Thiazine, but improved during course</b> (B) <b>Thiazine, but improved during course</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ASCD with Atrial fibrillation accentuated fever.</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>ASCD with Atrial fibrillation accentuated fever.</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____ that (I) (we) lost saw the deceased alive on _____ 19 _____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>P. Subb A Rao</b>		23B. DATE SIGNED <b>1/16/72</b>		23C. PHYSICIAN'S NAME (Type) <b>P. SUBB ARAO</b>	
23D. ADDRESS <b>South Baltimore Gen. Hospital</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/16/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Rosedale, Md.</b>	
24D. LOCATION (City, town, or county) (State) <b>Rosedale, Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>6010 Kensington Rd.</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

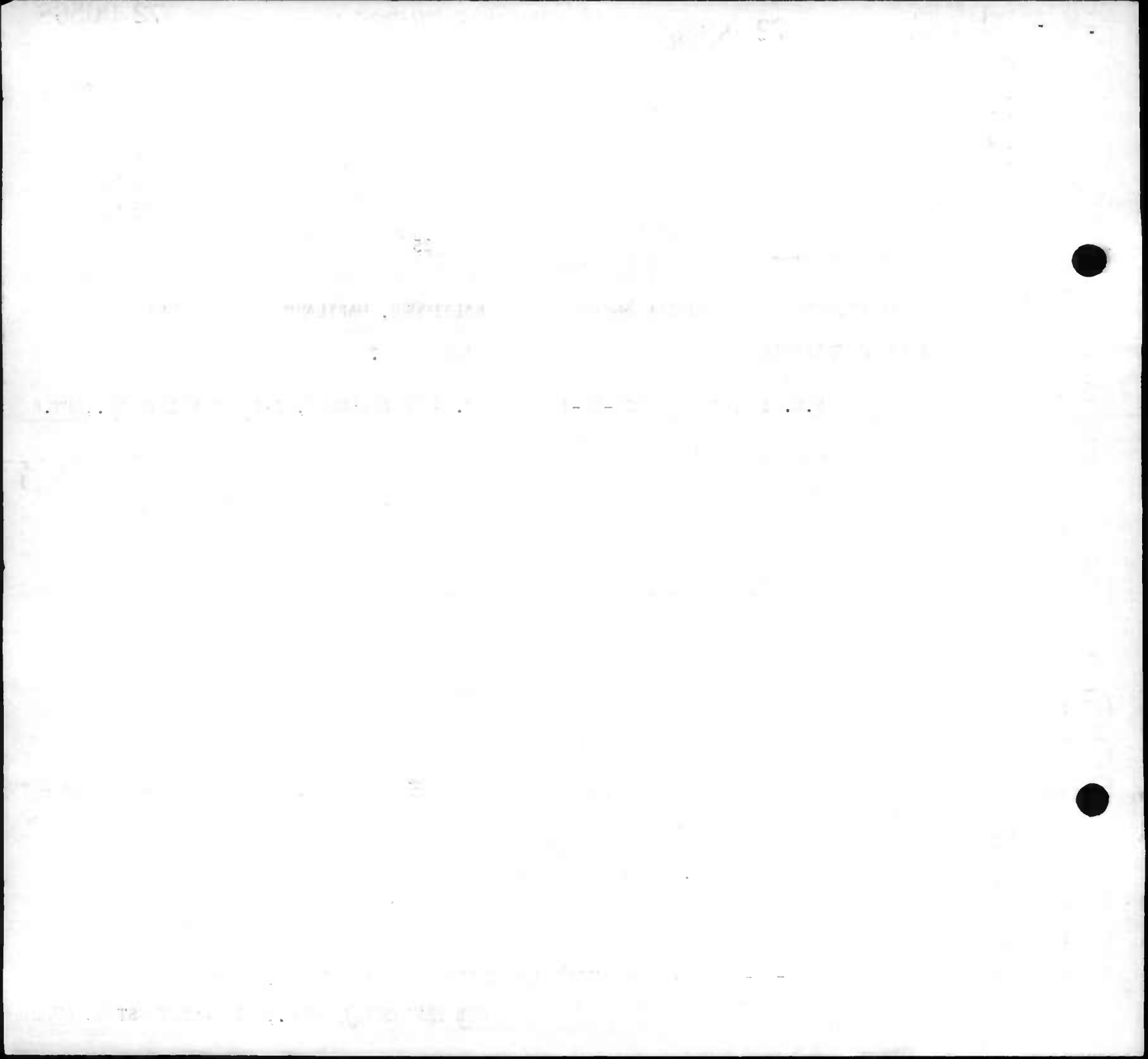
<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b>  <b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 00567</b></p>	
<p><b>BIRTH NO.</b>  <b>1. NAME OF DECEASED</b>          (Type or Print) <b>NETTIE KLEIN</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b>  <b>1/14/72 6:30 P.M.</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution, residence before admission)          A. STATE <b>MARYLAND</b> B. COUNTY <b># 21208 5300</b></p>		<p><b>5. CITY OR TOWN</b> <b>BALTIMORE</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)  <b>49 NORTH CHARLES GENTROP</b></p>		<p><b>E. STREET AND NUMBER</b> <b>7112 DEERFIELD ROAD</b>  <del>XXXXXXXXXXXXXXXXXXXX</del></p>	
<p><b>5. SEX</b> <b>FEMALE</b> <b>6. RACE</b> <b>white</b></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>  <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <b>1887 4/2/1887</b> <b>9. AGE</b> (in years lost birthday) <b>84</b></p>	<p><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)  <del>XXXXXXXXXX</del> <b>HOUSEWIFE</b></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)  <del>XXXXXXXXXX</del> <b>HOUSEWIFE</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>AT HOME</b></p>	
<p><b>11. BIRTHPLACE</b> (State or foreign country)  <del>XXXXXXXXXX</del> <b>RUSSIA</b></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b></p>	
<p><b>13. FATHER'S NAME</b>  <b>Issac Snyder</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b>  <b>Mariam ?</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)  <b>NO</b></p>		<p><b>16. SOCIAL SECURITY NO.</b> <b>NO</b></p>	
<p><b>17. INFORMANT</b> <b>MR. HOWARD KLEIN, 3420 GARRISON FRAMS RD. #8</b></p>		<p><b>ADDRESS</b></p>	
<p><b>18. CAUSE OF DEATH</b>  <b>43191</b></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>	
<p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>          (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>INTRACEREBRAL HEMORRHAGE</b></p>		<p><b>2 MONTHS</b></p>	
<p><b>ANTECEDENT CAUSES</b>          DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p><b>(A) IMMEDIATE CAUSE</b>  <b>DOE TO, OR AS A CONSEQUENCE OF:</b>  <b>BILATERAL PLEURAL EFFUSION</b>  <b>PNEUMONITIS</b></p>	
<p><b>(B) DOE TO, OR AS A CONSEQUENCE OF:</b>  <b>GENERALIZED ARTERIOSCLEROSIS</b></p>		<p><b>YEARS</b></p>	
<p><b>II</b>  <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b></p>			
<p><b>19A. DATE OF OPERATION</b> <b>0</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>20A. AUTOPSY?</b> (Yes or No)</p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)</p>	
<p><b>21E. INJURY OCCURRED</b>          While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from 12/27/1971 to 1/14/1972 that (I) (we) last saw the deceased alive on 1/14/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b>  <b>B. C. Veneracion Jr. MD.</b></p>		<p><b>23B. DATE SIGNED</b>  <b>1/14/72</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type)  <b>B. C. VENERACION Jr. MD.</b></p>		<p><b>23D. ADDRESS</b>  <b>NORTH CHARLES GEN HOSPITAL</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b>  <b>BURIAL</b></p>		<p><b>24B. DATE</b>  <b>1-16-72</b></p>	
<p><b>24C. NAME of CEMETERY or CREMATORY</b>  <b>BETH ISAAC ADATH ISRAEL</b></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State)  <b>BALTIMORE, MARYLAND</b></p>	
<p><b>25A. DATE RECEIVED BY HEALTH DEPT.</b>  <b>JAN 19 1972</b></p>		<p><b>25B. NAME OF REGISTRAR</b>  <b>JOHN E. GIBSON JR.</b></p>	
<p><b>25C. FUNERAL DIRECTOR</b>  <b>SOB. LEVINSON &amp; BROS.</b></p>		<p><b>ADDRESS</b>  <b>6010 REISTERSTOWN ROAD</b></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

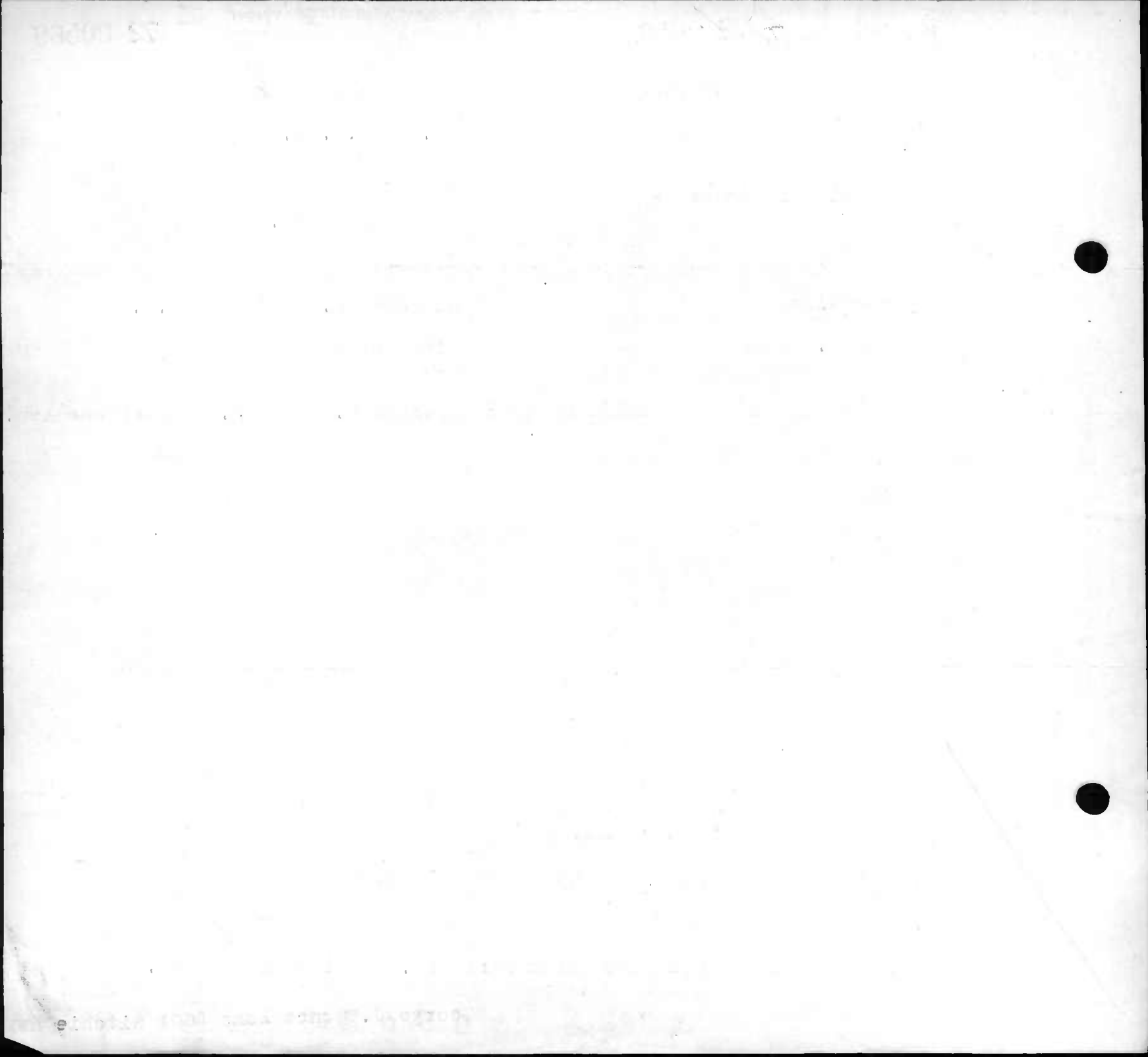
6-431 72 00568		BALTIMORE CITY HEALTH DEPARTMENT		72 00568	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>GOLDBERG, SAMUEL</b>			2. DATE AND HOUR OF DEATH <b>JAN. 15, 1972 5:00 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>42 SINAI HOSPITAL BALTIMORE</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3510 LABYRINTH RD. 21215</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/25/91</b>	9. AGE (in years last birthday) <b>80</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANUFACTURER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>WINDOW SHADES</b>		11. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>ABRAHAM GOLDBERG</b>		
14. MOTHER'S MAIDEN NAME <b>ANN ?</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES W.W. I NAVY</b>		
16. SOCIAL SECURITY NO. <b>220-30-1094</b>			17. INFORMANT ADDRESS <b>MRS. ANNE GOLDBERG, 3510 LABYRINTH RD., APT. B</b>		
18. CAUSE OF DEATH <b>410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION</b> <b>12 days</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>JAN. 8</b> 19 <b>72</b> to <b>JAN. 15</b> 19 <b>72</b> that (2) (we) last saw the deceased alive on <b>JAN. 15</b> 19 <b>72</b> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (not) view the body after death.					
23A. SIGNATURE <b>Armando C. Divamco, M.D.</b>			23B. DATE SIGNED <b>Jan. 15, 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>ARMANDO C. DIVAMCO M.D.</b>
23D. ADDRESS <b>SINAI HOSP. BALTIMORE, MD.</b>			24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		
24B. DATE <b>1-17-72</b>			24C. NAME OF CEMETERY or CREMATORY <b>CHIZUK AMUNO (ARLINGTON)</b>		
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MARYLAND</b>			25A. DATE REC'D BY HEALTH DEPT. <b>JAN 18 1972</b>		
25B. NAME OF REGISTRAR <b>SOB LEVINSON</b>			25C. FUNERAL DIRECTOR ADDRESS <b>BROS., 6010 REISTERSTOWN ROAD</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>B-600</b>		72 00569		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00569</b>	
1. NAME OF DECEASED (Type or Print) <b>Flora Mae Barr</b>				2. DATE AND HOUR OF DEATH <b>1 14 1972</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>43 South Baltimore General</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>A.A.Co.</b> C. CITY OR TOWN <b>Brooklyn</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>4903 Kramme Ave.</b>			
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8 20 1915</b>	9. AGE (In years last birthday) <b>56</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Altoona Pa.</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			
13. FATHER'S NAME <b>Roy F. Chase</b>				14. MOTHER'S MAIDEN NAME <b>Alma Gates</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>171 07 6872</b>		17. INFORMANT <b>James R. Barr Jr.</b> ADDRESS <b>4903 Kramme Ave.</b>	
18. <b>410191</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>A.S.C.V.D.</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1969</b> to <b>JAN 1972</b> that (I) (we) last saw the deceased alive on <b>DEC 16 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Mario J. Reda MD</b>				23B. DATE SIGNED <b>1/15/72</b>		23C. PHYSICIAN'S NAME (Type) <b>MARIO J. REDA MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>1 17 1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Alto Reste Park Cem.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>				25B. NAME OF REGISTRAR <b>George J. Gonce</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Home 4001 Ritchie Hwy</b>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-410 72 00570		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00570	
BIRTH NO.		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>WILLIAM GEORGE CZOLBA</u>		2. DATE AND HOUR OF DEATH <u>1-15-72</u> <u>12:25 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>SOUTH BALTIMORE GEN. HOSPITAL</u> <u>3001 S. HANOVER STREET</u> <u>43</u>		A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u> <u>5300</u>			
		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <u>3201-2nd Street</u>			
5. SEX <u>MALE</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-14-07</u>	9. AGE (in years lost birthday) <u>64</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAREHOUSEMAN</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>AMER. CAN. CO.</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>GEORGE (DEC.) CZOLBA</u>		14. MOTHER'S MAIDEN NAME <u>(?) (DEC.)</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>215-69-6252</u>		17. INFORMANT <u>EUGENE B. CZOLBA</u> ADDRESS <u>5254 FOURTH ST</u>	
18. <u>57191</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>HEPATIC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>? Cirrhosis liver</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
19. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____		21. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Dehydration &amp; multiple Vitamin Deficiency</u>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 14</u> 19 <u>72</u> to <u>Jan 15</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Jan 15</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Navalbant</u>		23B. DATE SIGNED <u>Jan 15-1972</u>		23C. PHYSICIAN'S NAME (Type) <u>N. KANT</u>	
23D. ADDRESS <u>South Balt. Gen. Hospital</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>1/18/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		24D. LOCATION (City, town, or county) (State) <u>A.A.Co. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Jones, R.D.</u>		25C. FUNERAL DIRECTOR <u>George J. Gonce, 4001 Ritchie Hwy., Baltimore, Md. 21225</u>	

2-14-07

Dr. [illegible]

[illegible]

[illegible]

[illegible]



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-523 72 00571		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00571	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) KNIGHT, MAUDE WILLIAMS		2. DATE AND HOUR OF DEATH JANUARY 16 1972 5 PM.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MD. B. COUNTY BALTIMORE COUNTY 2582		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229		E. STREET AND NUMBER 1616 DE SOTO ROAD			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10 08 92	9. AGE (in years last birthday) 79	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
13. FATHER'S NAME RANSON W. MEREDITH		14. MOTHER'S MAIDEN NAME ADDIE MOORE		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ST. AGNES HOSPITAL MEDICAL RECORDS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) 410.91 x 193.50 RENAL FAILURE		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: RENAL FAILURE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: Pneumonia		8 days	
		(C) Myocardial Infarction		9 days	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		Bob. Abdominal Carcinoma		Two years	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (X) (this hospital) attended the deceased from JANUARY 7 19 72 to JANUARY 16 19 72 that (X) (we) last saw the deceased alive on JANUARY 16 19 72 and that (our) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED Jan. 16. 1972			
23C. PHYSICIAN'S NAME (Type) Daniel Huerta M.D.		23D. ADDRESS Caton & Wilkens Ave. Balto, Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/72		24C. NAME of CEMETERY or CREMATORY St. Pauls Lutheran	
24D. LOCATION Baltimore, Maryland		24E. FUNERAL DIRECTOR Edw. S. MacNabb Sons, Inc.		24F. ADDRESS 101 Frederick Rd. Catonsville, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1972		25B. NAME OF REGISTRAR Jabab E. Saben		25C. ADDRESS 101 Frederick Rd. Catonsville, Md.	

1992

Country	1950	1960	1970	1980	1990	2000	2010	2020	2030	2040	2050
Japan	7.0	7.5	8.0	8.5	9.0	9.5	10.0	10.5	11.0	11.5	12.0
Germany	10.0	10.5	11.0	11.5	12.0	12.5	13.0	13.5	14.0	14.5	15.0
France	11.0	11.5	12.0	12.5	13.0	13.5	14.0	14.5	15.0	15.5	16.0
Italy	12.0	12.5	13.0	13.5	14.0	14.5	15.0	15.5	16.0	16.5	17.0
Spain	13.0	13.5	14.0	14.5	15.0	15.5	16.0	16.5	17.0	17.5	18.0
Sweden	14.0	14.5	15.0	15.5	16.0	16.5	17.0	17.5	18.0	18.5	19.0
Belgium	15.0	15.5	16.0	16.5	17.0	17.5	18.0	18.5	19.0	19.5	20.0
United Kingdom	16.0	16.5	17.0	17.5	18.0	18.5	19.0	19.5	20.0	20.5	21.0
United States	17.0	17.5	18.0	18.5	19.0	19.5	20.0	20.5	21.0	21.5	22.0
Canada	18.0	18.5	19.0	19.5	20.0	20.5	21.0	21.5	22.0	22.5	23.0
China	19.0	19.5	20.0	20.5	21.0	21.5	22.0	22.5	23.0	23.5	24.0
India	20.0	20.5	21.0	21.5	22.0	22.5	23.0	23.5	24.0	24.5	25.0
South Africa	21.0	21.5	22.0	22.5	23.0	23.5	24.0	24.5	25.0	25.5	26.0
South Korea	22.0	22.5	23.0	23.5	24.0	24.5	25.0	25.5	26.0	26.5	27.0
Poland	23.0	23.5	24.0	24.5	25.0	25.5	26.0	26.5	27.0	27.5	28.0
Ukraine	24.0	24.5	25.0	25.5	26.0	26.5	27.0	27.5	28.0	28.5	29.0
Russia	25.0	25.5	26.0	26.5	27.0	27.5	28.0	28.5	29.0	29.5	30.0
China (excl. HK)	26.0	26.5	27.0	27.5	28.0	28.5	29.0	29.5	30.0	30.5	31.0
China (incl. HK)	27.0	27.5	28.0	28.5	29.0	29.5	30.0	30.5	31.0	31.5	32.0
China (excl. HK) + India	28.0	28.5	29.0	29.5	30.0	30.5	31.0	31.5	32.0	32.5	33.0
China (incl. HK) + India	29.0	29.5	30.0	30.5	31.0	31.5	32.0	32.5	33.0	33.5	34.0

[illegible]

THE NEW YORK PUBLIC LIBRARY

100-443887-100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-256		72 00572		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00572	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH					
		Cusimano May Julia		Jan 15, 1972 11:30 P.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)		A. STATE		B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		Md. Anne Arundel		5200			
North Baltimore General Hospital				C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
				Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
				E. STREET AND NUMBER		8654 Roberts CT (Burwood Gardens)			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?		
Female	W	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	1/10/96	76	House Wife	Sicily	U.S.A		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Own Home				Antonino Ferrante		Angelina (unknown)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No		137-10,9261-D		Mrs. Vinnie Librick (daughter)		Glen Burnie, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		arterosclerotic					
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:		Cardiovascular disease					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)		renal failure					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?					
(Month) (Day) (Year) (Hour)		White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work							
22. I certify that (I) (this hospital) attended the deceased from		Dec 4 1971 to Jan 15 1972		that (I) (we) last saw the deceased alive on		Jan 15 1972 and that (in my) (our) opinion death occurred on the date			
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
Geo J. Noh M.D.		Jan 15-72		Geo J. Noh M.D.		So. Balto. Gen'l. Hosp., Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)			
Burial		Jan 19/72		Calvary Cemetery		Patterson, N.J.			
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS			
JAN 19 1972		R. E. [unclear]		R. E. [unclear]		Singleton Funeral Home		Glen Burnie, Md.	

(2000)

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

K-262

72 00573

BALTIMORE CITY HEALTH DEPARTMENT

72 00573

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>FRANCES KOSIOREK</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> <span style="float: right;">M.</span>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 423 Imla Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 13, 1972 10:20 A.M.</b>	
6. SEX <b>Female</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>White</b>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>3/29/1896</b>		10. AGE (In years last birthday) <b>75</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOMEMAKER</b>	
15. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>MR. JOS. KOSIOREK</b>	
19. <b>4124</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>IF</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>No</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>January 13, 1972</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/17/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>ST. STANISLAUS CEM</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Valerie E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>RAYMOND L. KACZOROWSKI</b>		ADDRESS <b>2525 FLEET ST.</b>	

75 10773

75 10773

WILLIAM L. KIMMER, JR. CO. OF CHICAGO

CHICAGO, ILL.

DECEMBER 1, 1911

1

WILLIAM L. KIMMER, JR.

CHICAGO, ILL.

WILLIAM L. KIMMER, JR.

CHICAGO, ILL.

WILLIAM L. KIMMER, JR.  
CHICAGO, ILL.

WILLIAM L. KIMMER, JR.  
CHICAGO, ILL.

WILLIAM L. KIMMER, JR.  
CHICAGO, ILL.

WILLIAM L. KIMMER, JR.  
CHICAGO, ILL.

WILLIAM L. KIMMER, JR.  
CHICAGO, ILL.

WILLIAM L. KIMMER, JR.  
CHICAGO, ILL.

WILLIAM L. KIMMER, JR.  
CHICAGO, ILL.

WILLIAM L. KIMMER, JR.  
CHICAGO, ILL.

WILLIAM L. KIMMER, JR.  
CHICAGO, ILL.

WILLIAM L. KIMMER, JR.  
CHICAGO, ILL.

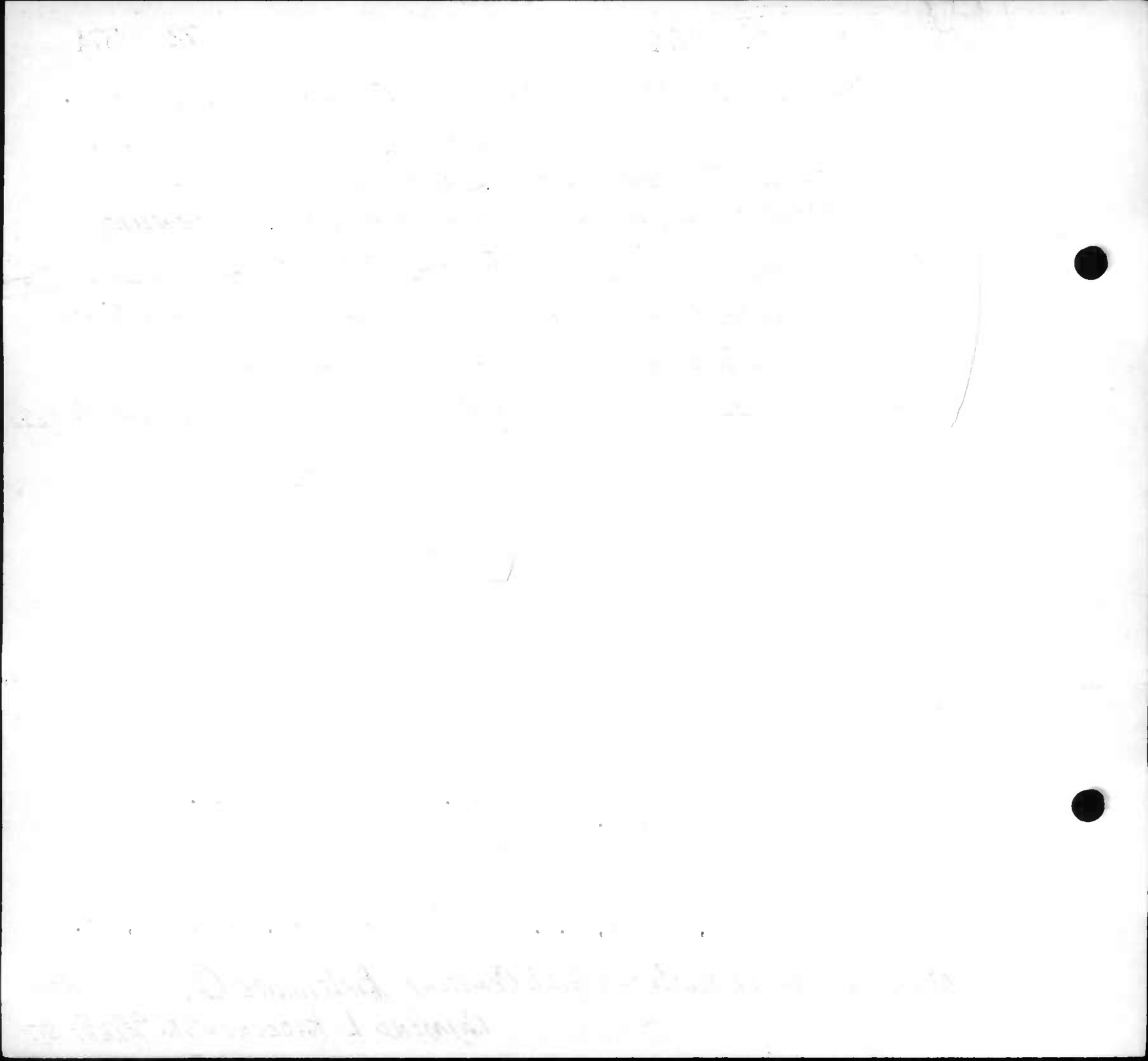
WILLIAM L. KIMMER, JR.  
CHICAGO, ILL.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>M-266</span> <span>72 00574</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2> <div style="display: flex; justify-content: space-between;"> <span>REG. NO.</span> <span>72 00574</span> </div>			
BIRTH NO. <span style="float: right;">1</span> 1. NAME OF DECEASED (Type or Print) <u>JAMES E. McCRORY</u>		2. DATE AND HOUR OF DEATH <u>JANUARY 13 1972</u> <u>7:15P.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>2613 FOSTER AVE.</u> <u>00 BALTIMORE, MD.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>103</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>2613 FOSTER AVENUE</u>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 21, 1919</u>
9. AGE (in years last birthday) <u>52</u> <u>53 yrs.</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TOOL &amp; DIE INSPECTOR AAI CORP.</u> 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>JAMES McCRORY</u>		14. MOTHER'S MAIDEN NAME <u>BERTHA LAMP</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W. W. II</u>		16. SOCIAL SECURITY NO. <u>MRS. MARGARET McCRORY 2613 FOSTER</u>	
18. <u>188X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <u>Adenocarcinoma of Urinary Bladder</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 1/2 Yrs</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>No</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Oct. 19 67</u> to <u>Jan. 13 1972</u> that (I) (we) last saw the deceased alive on <u>Jan. 13 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <u>He</u> (we) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Clarence W. LeDoux</u>		23B. DATE SIGNED <u>1/15/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Clarence W. LeDoux, M.D.</u>		23D. ADDRESS <u>3023 Eastern Ave. Baltimore, Md.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>JAN. 17, 1972</u>	24C. NAME OF CEMETERY OR CREMATORY <u>CEDAR HILL CEMETERY</u>	24D. LOCATION (City, town, or county) (State) <u>BALTIMORE CO. MD.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1972</u>	25B. NAME OF REGISTRAR <u>Robert E. Nafziger, M.D.</u>	25C. FUNERAL DIRECTOR <u>RAYMOND A. KACZOROWSKI</u> ADDRESS <u>2525 FLEET ST.</u>	



**B-435** 72 00575 BALTIMORE CITY HEALTH DEPARTMENT  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH** REG. NO. **72 00575**

**BIRTH NO.**

1. NAME OF DECEASED (Type or Print) <b>NEIL Martin N. Bolton, Sr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>1</b> Day <b>11</b> Year <b>72</b> Hour <b>12:25A.</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>CERTIFICATE AMENDED</b> <b>35 Church Home &amp; Hospital</b> 1-24-72		3. DATE PRONOUNCED DEAD Month <b>1</b> Day <b>11</b> Year <b>72</b> Hour <b>12:25A.</b> M.	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>JUNE 13 1922</b>		10. AGE (In years lost birthday) <b>49</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>TALMADGE BOLTON</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>10.3</b>	
15. MOTHER'S MAIDEN NAME <b>MARY MORCANWICK</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>MRS. ANNA E. BOLTON</b> ADDRESS <b>2501 Foster Ave</b>	
19. <b>E 965X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of abdomen</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Gunshot wound of abdomen complicated by peritonitis</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Unknown</b>		22D. TIME (Month) (Day) (Year) (Hour) (Minute) (Approx.) <b>1-4-1972 1:55 P</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot by unknown assailant</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. NAME (Type) <b>Werner U. Spitz, M.D.</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>JAN 15 1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MORELAND MEM. CEM</b>		24D. LOCATION (City, town, or county) (State) <b>BALTIMORE MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Raymond L. Kaczorowski</b>		ADDRESS <b>2523 FLEET STREET</b>	

VS 151-REV. 7/1/68

1-24-1972 - Letter from - Office of the Chief Medical Examiner, Werner U. Spitz, M.D.  
Deputy Chief Medical Examiner

HRS

P-626

72 00576

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00576

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Robert Parker		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 16 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 1708 Light St. - Apt. 17		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 16 72 9:39 a.m.	
6. SEX male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 2/18/09		10. AGE (In years last birthday) 62	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Guard		14B. KIND OF BUSINESS OR INDUSTRY City Jail	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 274-03-5901	
18. INFORMANT Richard D. Parkerm		ADDRESS 1508 Riverside Ave.	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME (Month) (Day) (Year) (Hour) (Approx.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE Peter Lipkovic, M.D. EXAMINER'S NAME (Type) Peter Lipkovic, M.D. DATE SIGNED 1/16/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/72	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1972		25B. NAME OF REGISTRAR Robert E. Juby, M.D.	
25C. FUNERAL DIRECTOR Mc Cully Funeral Homes		ADDRESS 130 E. Fort Ave.	

15 10216

15 10216

15 10216

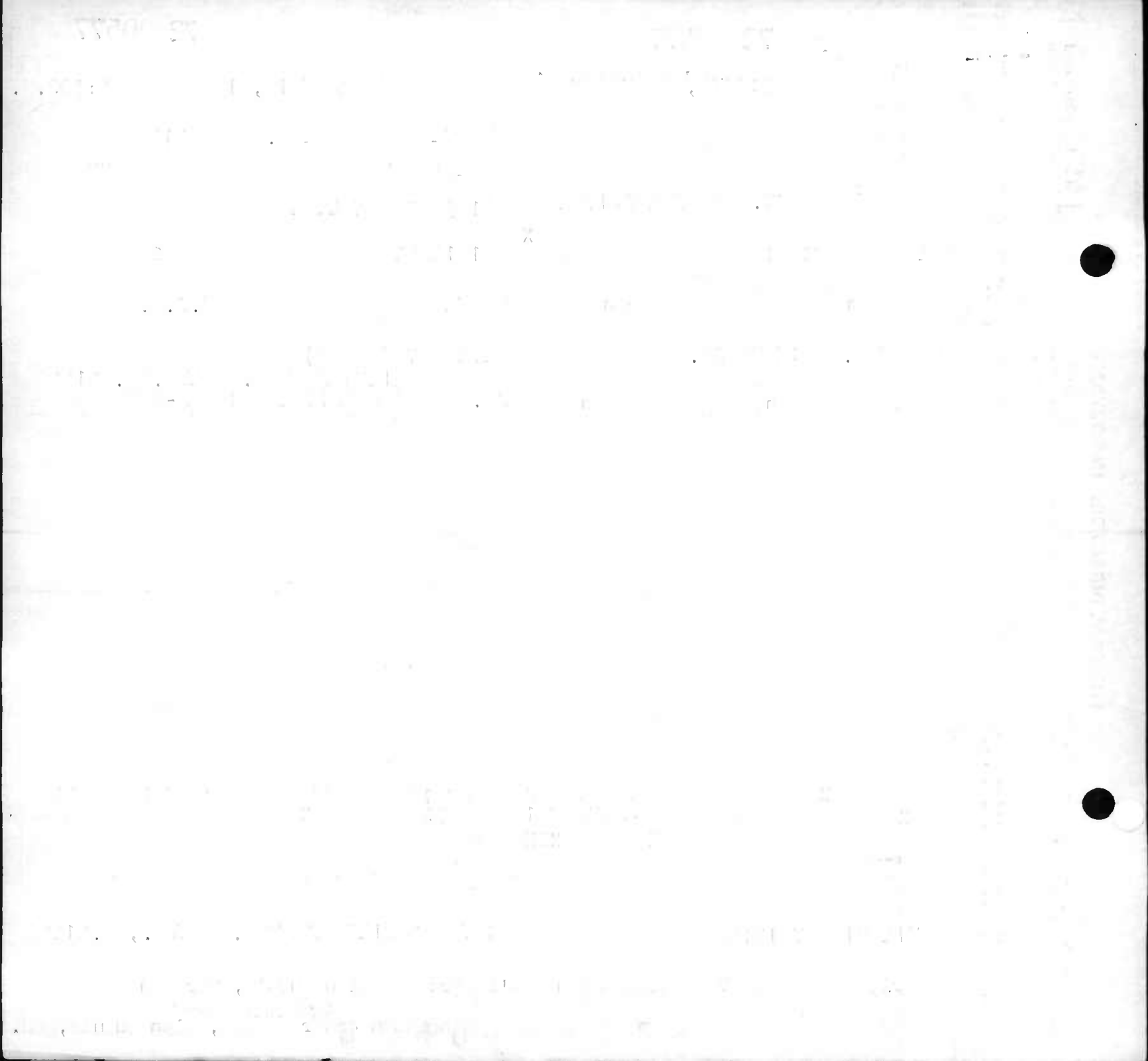
x



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00577</u>
<b>BIRTH NO.</b> <u>72 00577</u> <b>1. NAME OF DECEASED</b> (Type or Print) <u>DeKett, Douglas A.</u> <del>XXXXXX</del> , <del>XXXXXXXX</del>		<b>2. DATE AND HOUR OF DEATH</b> <u>JANUARY 16, 1972</u> <u>2:30 PM.</u>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <u>40 ST. AGNES HOSPITAL</u> <b>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <u>MARYLAND</u> <b>B. COUNTY</b> <u>BALTO.</u> <b>C. CITY OR TOWN</b> <u>BALTIMORE</u> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>4173 MC DOWELL LANE</u>		
<b>5. SEX</b> <u>MALE</u>	<b>6. RACE</b> <u>CAUCASIAN</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>01 14 72</u>	<b>9. AGE</b> (In years last birthday) <u>2</u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>None</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>MARYLAND</u>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>RODNEY O. DECKETT SR.</u>		
<b>14. MOTHER'S MAIDEN NAME</b> <u>ELIZABETH (BOONE)</u>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u> <u>None</u>		
<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT</b> <u>WILKENS AVES. BALTO. MD. 21229</u> <u>ST. AGNES HOSPITAL RECORDS-CATON &amp;</u>		
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> <u>776.1 I</u> [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>
<b>(A) IMMEDIATE CAUSE</b> <u>Cerebral hemorrhage.</u> <b>DUE TO, OR AS A CONSEQUENCE OF:</b>				
<b>(B) <u>Hyaline membrane disease</u></b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b>				
<b>(C)</b>				
<b>19A. DATE OF OPERATION</b> <u>2</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <u>YES</u>
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>				
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (Approx.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that</b> <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JANUARY 14</u> 19 <u>72</u> to <u>JANUARY 16</u> 19 <u>72</u> that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on <u>JANUARY 16</u> 19 <u>72</u> and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) (did not) view the body after death.				
<b>23A. SIGNATURE</b> <u>Vilavian Thitivarana, M.D.</u>				<b>23B. DATE SIGNED</b> <u>1-16-72</u>
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>VILAVIAN THITIVARANA</u>		<b>23D. ADDRESS</b> <u>CATON &amp; WILKENS AVES. BALTO., MD. 21229</u>		
<b>24A. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>24B. DATE</b> <u>1/18/72</u>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>Glen Haven Mem'l Park</u>
<b>24D. LOCATION</b> (City, town, or county) (State) <u>Glen Burnie, Maryland</u>				
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 19 1972</u>		<b>25B. NAME OF REGISTRAR</b> <u>James E. Naiten, M.D.</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Singleton Funeral Home, Glen Burnie, Md.</u>

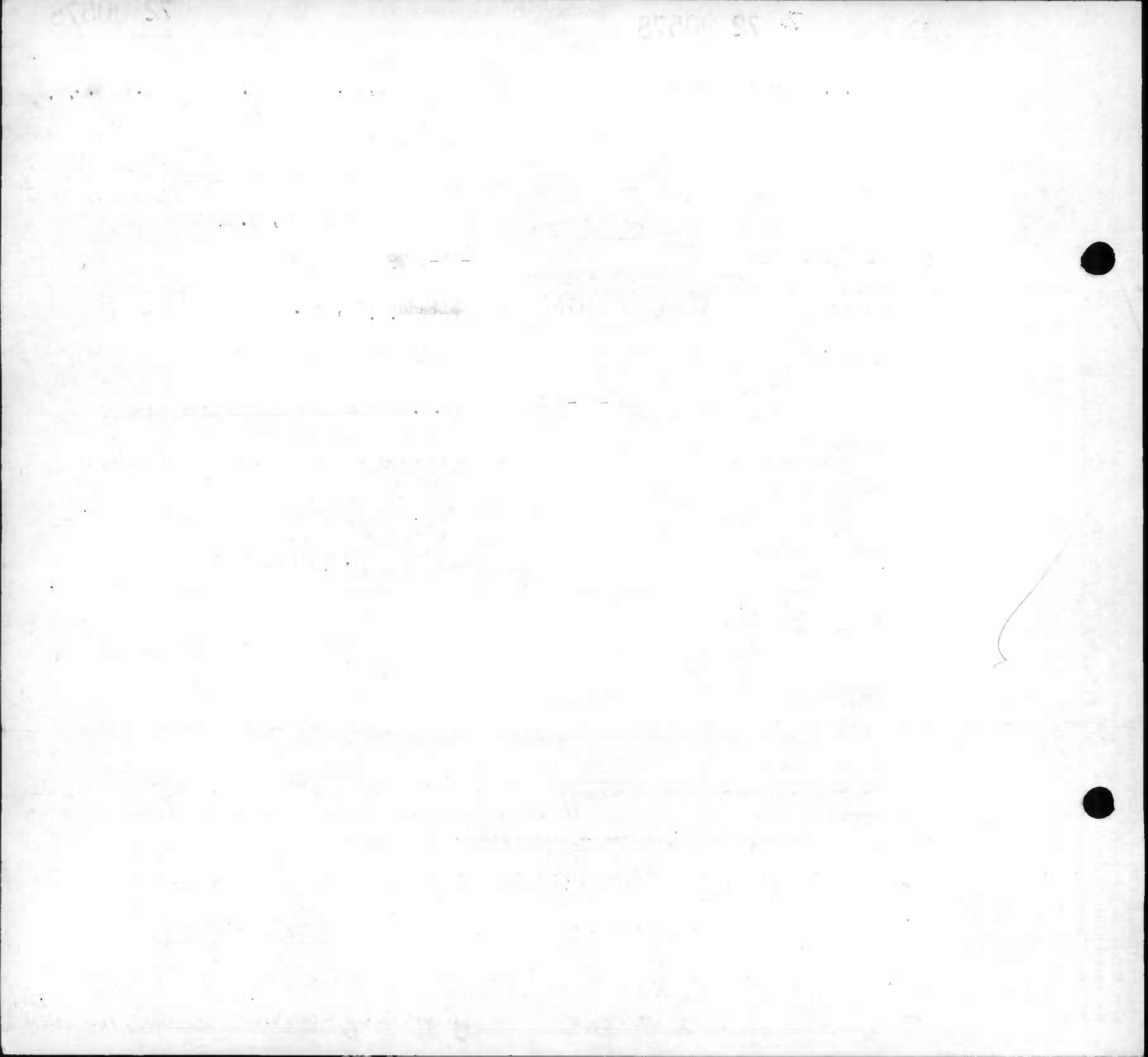




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R 100		72 00578		BALTIMORE CITY HEALTH DEPARTMENT		72 00578	
BIRTH NO.		CERTIFICATE OF DEATH				Registered No. _____	
M.E. CASE NO.		1. NAME OF DECEASED (Type or Print) <b>Sr. M. Pascaline Raabe</b>				2. DATE AND HOUR OF DEATH <b>1,13,1972 11:15 A.M.</b>	
3. PLACE OF DEATH IN BALTIMORE, MARYLAND				4. USUAL RESIDENCE (Where deceased lived, if institution; residence if not institution) A. STATE <b>MARYLAND</b> B. COUNTY <b>111</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>901 Aisquith St.</b>		(If not in hospital or institution, give street address or location)		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALT. MD.</b>		D. STREET ADDRESS (If rural, give location) <b>901 AISQUITH ST</b>	
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED, <del>NEVER MARRIED</del> WIDOWED, DIVORCED (specify)		8. DATE OF BIRTH <b>6-15-1879</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Teacher</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>EDUCATION</b>		11. BIRTHPLACE (State or foreign country) <b>Philadelphia, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Krein</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>216-54-3918</b>		17. INFORMANT <b>Sr. M. Kostka</b>		ADDRESS <b>901 Aisquith Street</b>	
18. <b>25-0-91</b>		CAUSE OF DEATH				INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) <b>Pneumonia</b> DUE TO				(B) <b>arteriosclerotic Cardiovascular disease</b> DUE TO	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) <b>Diabetes Mellitus</b> DUE TO				(D) <b>yes.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>9 AUG 1969</b> to <b>11 Jan 1972</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>11 JAN 1972</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.		23A. SIGNATURE <b>Salvatore R. Donohue M.D.</b>	
23B. PHYSICIAN'S NAME (Type) <b>SALVATORE R. DONOHUE M.D.</b>		23C. ADDRESS <b>MARYLAND GEN. HOSP.</b>		23D. DATE SIGNED <b>14 Jan 72</b>		23E. Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-17-72</b>		24C. NAME OF CEMETERY <b>SISTERS CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>GLEN ARM, BALT. CT. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Raymond Curran</b>		25C. FUNERAL DIRECTOR <b>Raymond Curran</b>		ADDRESS <b>817 SCARLETT DR. TOWSON, MD 21204</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 00579</span>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">72 00579</span>
1. NAME OF DECEASED (Type or Print) <b>ABRAMS, Frank</b>		2. DATE AND HOUR OF DEATH <b>Jan 14 1972</b> <span style="float: right;">P.M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>B</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>Union Memorial Hospital</b> <b>44</b>		710 ST Paul Street. <b>B 21202 1102</b>		C. CITY OR TOWN <b>Baltimore Md</b>
		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
		E. STREET AND NUMBER		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10-26-07</b>	9. AGE (In years last birthday) <b>70</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Lumber Inspector</b>		11. BIRTHPLACE (State or foreign country) <b>PENNA</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		13. FATHER'S NAME <b>George ABRAMS</b>		
14. MOTHER'S MAIDEN NAME <b>Sarah - Kirk</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>236 07 8025</b>		17. INFORMANT <b>Hanna E. Abrams</b> Same as Above		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>410.94-250.9</b> <b>Myocardial infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 minutes</b>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>gangrene left foot &amp; diabetes</b>		
		(B) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF:		
		(C)		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes Mellitus &amp; gangrene left foot</b>				
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) Month ( ) Day ( ) Year ( ) Hour ( )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 2nd 1972</b> to <b>Jan 14 1972</b> that (I) (we) last saw the deceased alive on <b>Jan 14 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Robert E. Martin, M.D.</b>		23B. DATE SIGNED <b>Jan 14 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>Robert E. Martin, M.D.</b>
23D. ADDRESS <b>3201 No Charles.</b>		23E. FUNERAL DIRECTOR <b>Leopold J. Ruck, Inc. Balto., Md.</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/17/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>
24D. LOCATION <b>Baltimore, Md.</b>		24E. NAME OF REGISTRAR <b>John A. ...</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>John A. ...</b>		

Importation

James L. Adams, Jr.

...

...

...

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-655 72 00580				BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00580	
1. NAME OF DECEASED (Type or Print) Anna J. Bormuth				2. DATE AND HOUR OF DEATH 1-15-72 2:00 A.M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 37 Mercy Hosp.				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Md B. COUNTY BALTO 5300 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 2516 Wycliffe Road					
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9/20/1922		9. AGE (In years last birthday) 49		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Owen J. O'Neill				14. MOTHER'S MAIDEN NAME Mary H. Stump					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO.		17. INFORMANT James G. Bormuth same ADDRESS			
18. 15-381 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ACUTE PERITONITIS ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Acute Peritonitis Aspiration (B) DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of colon with multiple abdominal meta- (C) stasis.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (A) (this hospital) attended the deceased from 1/14 1971 to 1/15 1971 that (A) (we) last saw the deceased alive on 1/15 1971 and that in (A) (our) opinion death occurred on the date and hour and from the causes stated above. (A) (We) (did) (not) view the body after death.									
23A. SIGNATURE Kenneth R. Warrick M.D.				23B. DATE SIGNED				23C. PHYSICIAN'S NAME (Type) Kenneth R. Warrick M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/72		24C. NAME of CEMETERY or CREMATORY Holy Redeemer		24D. LOCATION (City, town, or county) (State) Ba lto. Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1972		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Leonard J. Luck Inc.		ADDRESS Ba lto. Md.			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-610		72 00581		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00581	
1. NAME OF DECEASED (Type or Print) <b>GREB, FERN LOUISE</b>				2. DATE AND HOUR OF DEATH <b>JANUARY 16, 1972 7:48 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 ST. AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>Highlands</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>2921 OHIO AVE.</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>08 14 28</b>	9. AGE (In years last birthday) <b>43 28</b>	10. If Under 1 Yr. Months Days	11. If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>EDWIN MILLER</b>			
14. MOTHER'S MAIDEN NAME <b>FLORENCE (Ebling)</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			
16. SOCIAL SECURITY NO. <b>218-26-3066</b>				17. INFORMANT ADDRESS <b>WILKENS AVES. BALTO. MD. 21229</b> <b>ST. AGNES HOSPITAL RECORDS-CATON &amp;</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Subarachnoid hemorrhage</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cerebral lesion (Non traumatic)</b>			
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Traumatic</b>			
21. (C) DUE TO, OR AS A CONSEQUENCE OF:							
22. I certify that (X) (this hospital) attended the deceased from <b>JANUARY 13</b> 19 <b>72</b> to <b>JANUARY 16</b> 19 <b>72</b> that (X) (we) last saw the deceased alive on <b>JANUARY 16</b> 19 <b>72</b> and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (3) (4) (5) view the body after death.							
23A. SIGNATURE <b>Sam Pedro</b>				23B. DATE SIGNED <b>01 16 72</b>		23C. PHYSICIAN'S NAME (Type) <b>SERGIO SAN PEDRO M.D.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>				24B. DATE <b>1-19-1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Washington Blvd., Howard Co., Md.</b>				25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>			
25B. NAME OF REGISTRAR <b>Howard H. Hubbard</b>				25C. FUNERAL DIRECTOR ADDRESS <b>4107 Wilkens Ave. 21229</b>			

12-19-55

12-19-55

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

X

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.

1. 1. 1.



S-126

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Harold S. Spicer</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 14 72</b> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>48 Maryland General Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 14 72 10:15 a.</b> M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Balto.</b> C. CITY OR TOWN <b>Reisterstown</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
6. SEX <b>male</b>	7. RACE <b>White</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		E. STREET AND NUMBER <b>6 Sunnydale Way</b>			
9. DATE OF BIRTH <b>Oct. 30, 1919</b>		10. AGE (In years last birthday) <b>52</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harold S. Spicer</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Photographer</b>		15. MOTHER'S MAIDEN NAME <b>Gladys</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes. WW II</b>	
17. SOCIAL SECURITY NO. <b>218-01-5259</b>		18. INFORMANT <b>Dorothy I. Spicer</b>		19. CAUSE OF DEATH <b>E 9651 X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of head</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>CAR</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Druid Park Drive</b>			
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>1 14 72 unk</b>		22E. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject shot by unknown assailant</b>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic</b> M.D. EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> DATE SIGNED <b>1/14/72</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>Jan. 17, 1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Ft. Lincoln Crematory</b>		24D. LOCATION (City, town, or county) (State) <b>Washington 18, D.C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Gable, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H. J. Schhardt Owings Mills, Md.</b>			

23-10028

23-10028

10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

10-10-10

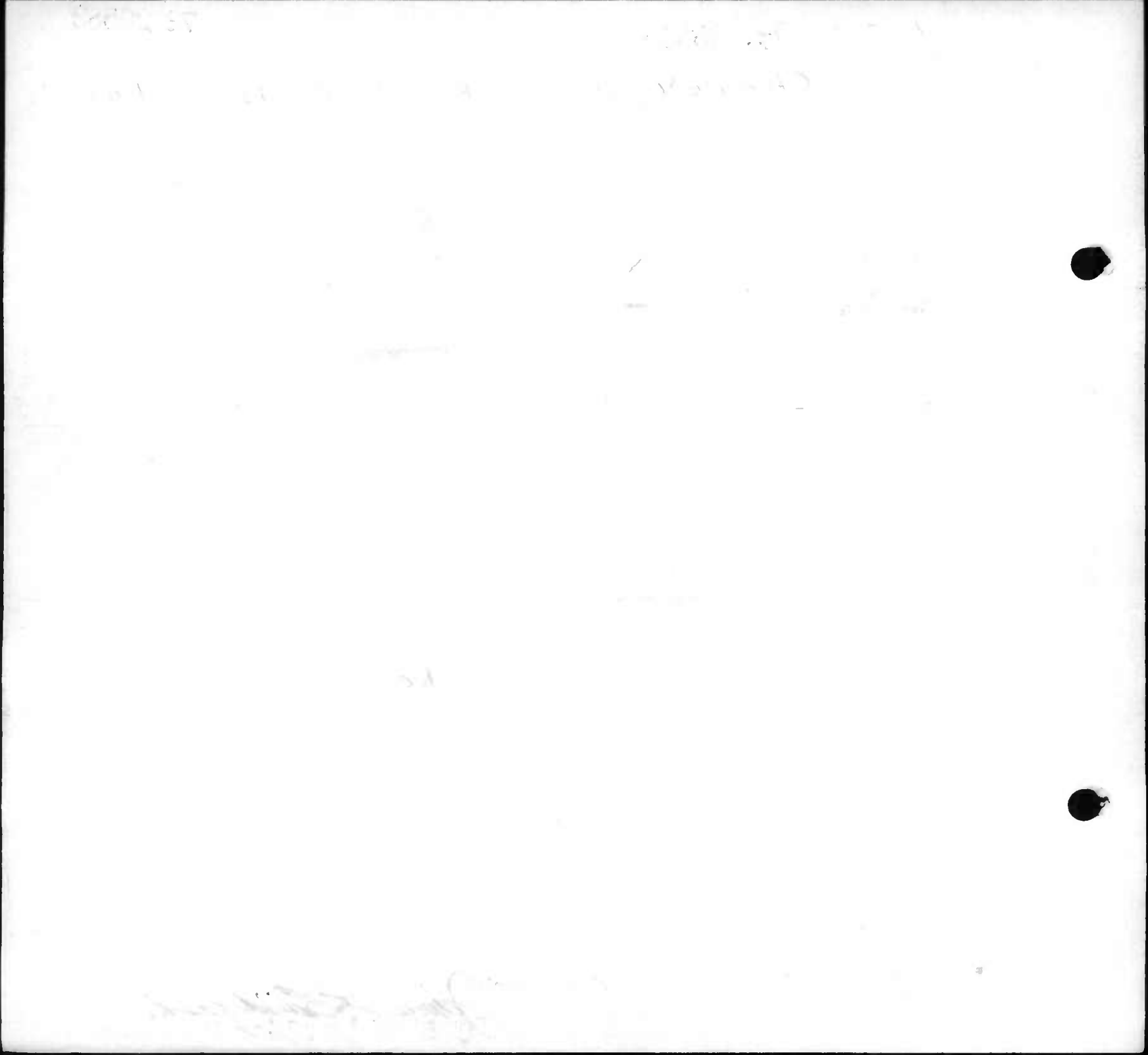
10-10-10

10-10-10

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 00583</span>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">72 00583</span>	
1. NAME OF DECEASED (Type or Print) <b>CHANEY, JOSEPH. F.</b>		2. DATE AND HOUR OF DEATH <b>15 Jan 72 1:05 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home &amp; Hospital 100 N. Broadway</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>301</b>			
		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>10. South Broadway</b>			
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-15-95</b>	9. AGE (In years last birthday) <b>72</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Cash Maker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>George Chaney</b>			
14. MOTHER'S MAIDEN NAME <b>Annista Cummings</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No -</b>			
16. SOCIAL SECURITY NO. <b>218 10 6006</b>		17. INFORMANT <b>Mildred Palamka</b> ADDRESS <b>Golden Ring Rd.</b>			
18. <b>33091</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Stagnation</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Respiratory failure</b> <b>(B) Antecedent Cause DUE TO, OR AS A CONSEQUENCE OF: Esophageal pleural fistula</b> <b>(C) Empyema</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 month</b>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>-</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>-</b>		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>-</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>-</b>			
21D. TIME OF INJURY (Approx.) <b>-</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>-</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>12-29-1971</b> to <b>1-15-1972</b> that (I) (we) last saw the deceased alive on <b>1-15-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>A. Mehta</b>		23B. DATE SIGNED <b>1/15/72</b>		23C. PHYSICIAN'S NAME (Type) <b>ASHWIN MEHTA</b>	
23D. ADDRESS <b>Church Home &amp; Hosp. Balto no 21231</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1/18/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Howard Co., Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Kelly</b>		25C. FUNERAL DIRECTOR <b>Bruzdzinski Funeral Home</b> ADDRESS <b>1407 Eastern Ave</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

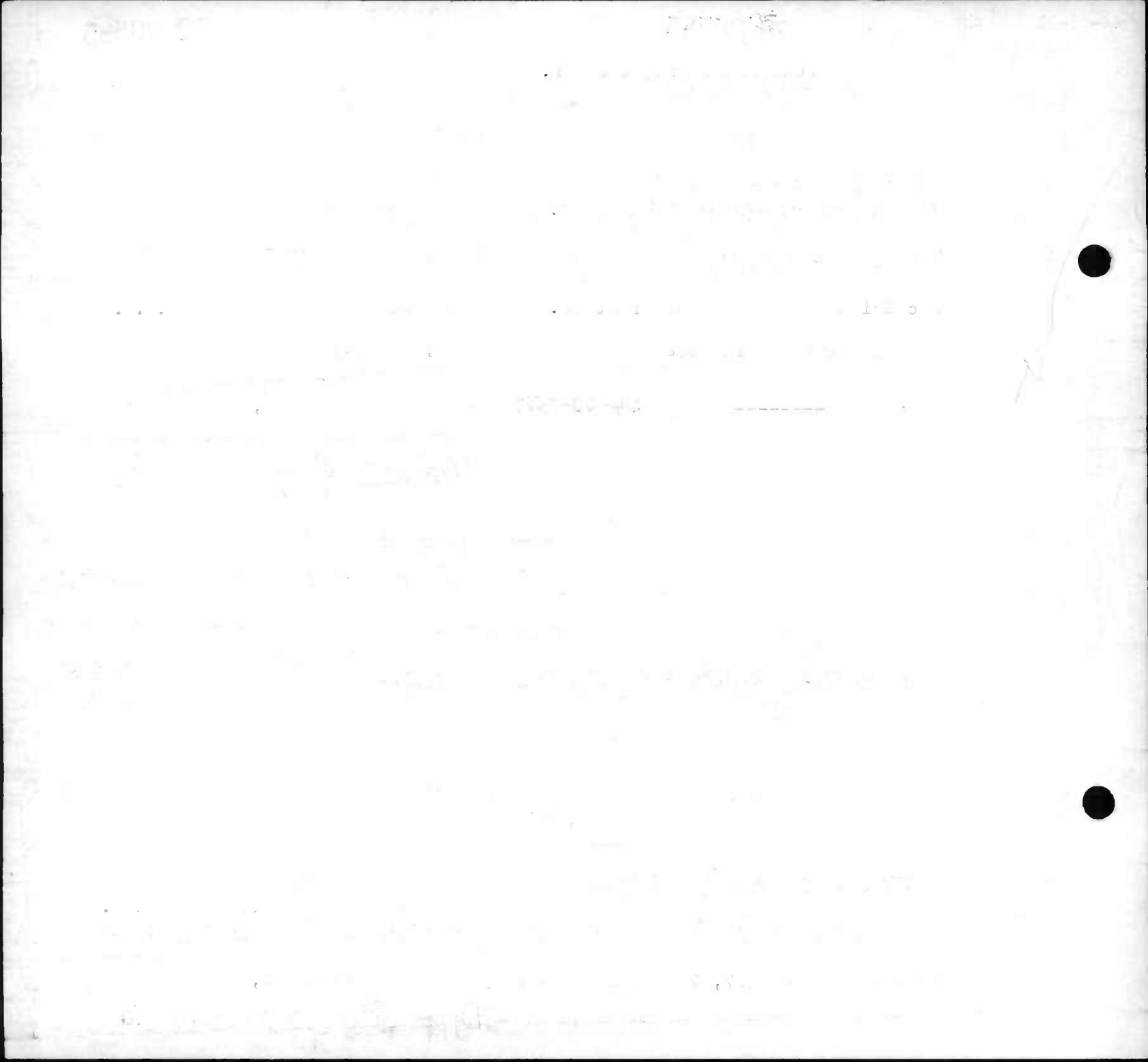
1. NAME OF DECEASED (Type or Print) <b>Thomas Edward Hall</b>		2. DATE AND HOUR OF DEATH <b>Jan. 16, 1972</b> <b>12:30 PM</b> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>US Public Health Service Hospital</b> <b>3100 Wyman Parkway</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2713</b>	
5. SEX <b>M</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/8/35</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Factory worker</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SOAP</b>	9. AGE (In years last birthday) <b>36</b>
11. BIRTHPLACE (State or foreign country) <b>Del.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles Hall</b>		14. MOTHER'S MAIDEN NAME <b>Hettie Shockley</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes USA 1954-1959</b>		16. SOCIAL SECURITY NO. <b>212-32-4485</b>	
17. INFORMANT <b>Records - US PHS Hospital, Balto, Md.</b>		ADDRESS	
18. <b>201X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Hodgkin's disease, lymphocytic depletion, with metastases to liver &amp; thoracic, abdominal &amp; cervical lymph nodes</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 1/2 mos.</b>	
19A. DATE OF OPERATION <b>1/6/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Staging of Hodgkin's disease</b>	
20A. AUTOPSY? (Yes or No) <b>yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <input type="checkbox"/>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (Y) (this hospital) attended the deceased from <b>Dec. 28</b> 19 <b>71</b> to <b>Jan. 16</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>Jan. 16</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (Y) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Robert R. Wright, MD</b>		23B. DATE SIGNED <b>1/17/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert Wright, SA Surg (R)</b>		23D. ADDRESS <b>US PHS Hospital, Balto, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/19/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>OAK LAWN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>John E. Kelly, Jr.</b>	
25C. FUNERAL DIRECTOR <b>J. E. GONNELLY</b>		ADDRESS <b>300 MACE</b>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

44-86-01		1 sh		101-623 72 00585		CERTIFICATE OF DEATH		REG. NO. 72 00585	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>JOHN BRUFF WRIGHTSON Sr.</b>		2. DATE AND HOUR OF DEATH <b>11/14/72 1:45 A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>102</b>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>1 BALTIMORE CITY</b> <b>4940 Eastern Ave HOSPITALS 21224</b>		E. STREET AND NUMBER <b>534 S Decker Avenue</b>							
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/30/93</b>	9. AGE (In years last birthday) <b>78</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Die Craft Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>unknown Wrightson</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ahlers</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-22-7587</b>		17. INFORMANT ADDRESS <b>4940 Eastern Avenue</b> <b>BCH-Records Baltimore, Maryland 21224</b>	
18. <b>427.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>2 DAYS</b>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>SEPTICEMIA</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>3 DAYS</b>							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>RENAL FAILURE</b>		(C) DUE TO, OR AS A CONSEQUENCE OF: <b>3 DAYS</b>							
19A. DATE OF OPERATION <b>3/13/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>CHOLECYSTITIS</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>YES</b>			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <input type="checkbox"/>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>11/15</b> 19 <b>72</b> to <b>1/14</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/14</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Leslie Pearlstein MD</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1/14/72</b>					
23C. PHYSICIAN'S NAME (Type) <b>LESLIE PEARLSTEIN MD</b>		23D. ADDRESS <b>4940 Eastern Ave., Baltimore, Md. 21224</b> <b>BALTO. CITY HOSPITALS</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>Jan 17, 72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Oaklawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Regis. 720</b>		25C. FUNERAL DIRECTOR <b>Dippel Boos</b>		ADDRESS <b>7110 Bonair Rd</b>			

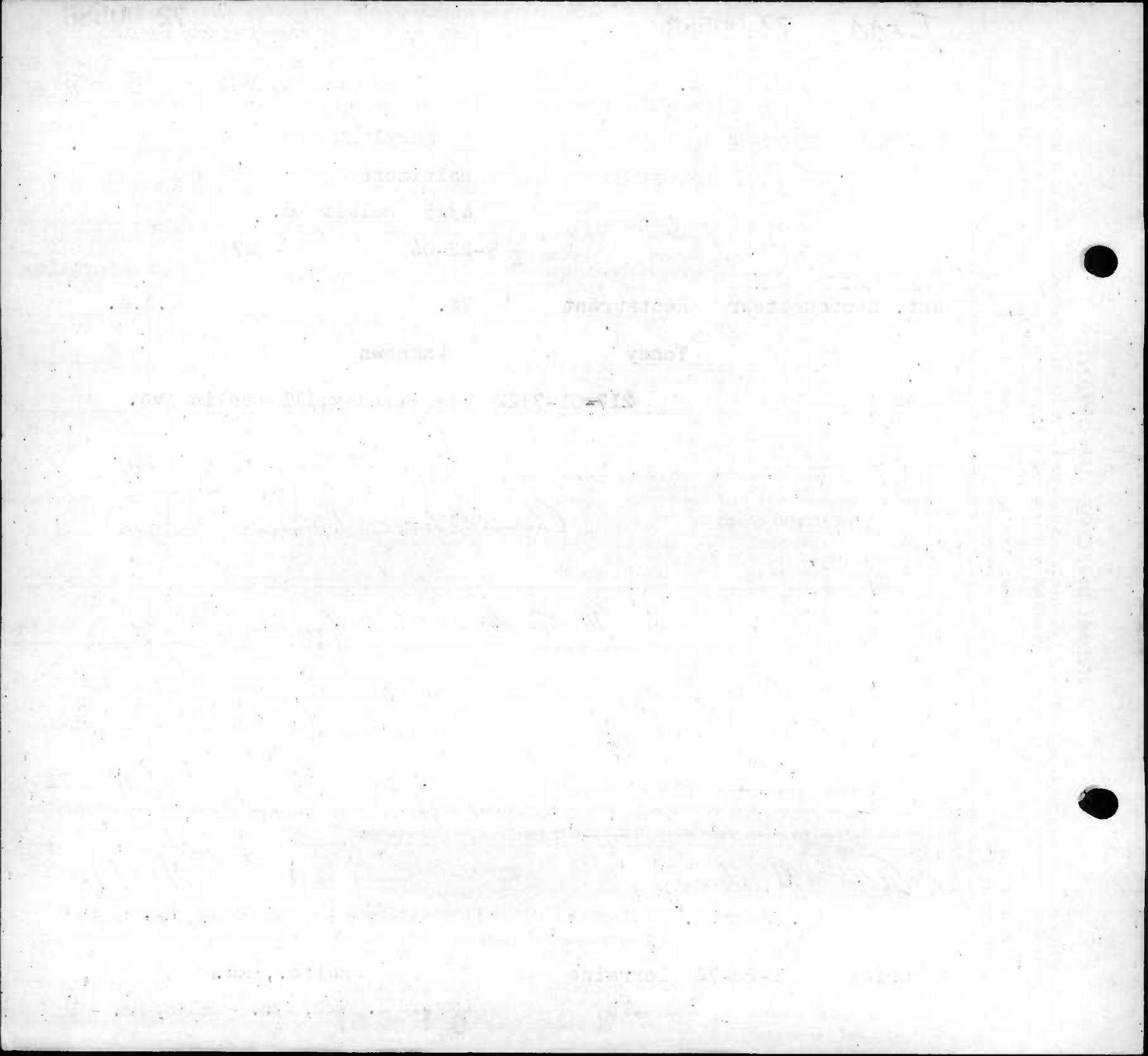




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00586</span>	
T-500 72 00586				CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		EDWARD W. TONEY		January 18, 1972 <span style="float: right;">3<sup>45</sup> P M.</span>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>90 HOUSE IN THE PINES BELAIRE</b>				A. STATE <b>Maryland</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY	
				C. CITY OR TOWN <b>Baltimore</b>	
				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>4325 Belair Rd.</b>	
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9-22-04</b>	9. AGE (In years last birthday) <b>67</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Restaurateur</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>		11. BIRTHPLACE (State or foreign country) <b>Va.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Toney</b>		
14. MOTHER'S MAIDEN NAME <b>Unknown</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>217-01-7322</b>			17. INFORMANT <b>John Handley, 111 Leslie Ave.</b>		
18. <b>492X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>RECURRENT PNEUMONIA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CHRONIC OBSTRUCTIVE EMPHYSEMA</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) <b>CHRONIC OBSTRUCTIVE EMPHYSEMA</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>MULTIPLE STROKE &amp; BILATERAL HEMIPARESIS</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>4/29/1978</b> to <b>1/18/1972</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>1/16/1972</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <b>Albert B. Bradley</b>				23B. DATE SIGNED <b>1/18/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Dr. Albert B. Bradley</b>				23D. ADDRESS <b>4900 Belair Road, Baltimore, Maryland</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-20-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Lorraine</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc. - Balto, Md. - 11</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-155		72 00587		BALTIMORE CITY HEALTH DEPARTMENT		72 00587	
CERTIFICATE OF DEATH				REG. NO. _____			
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>MAUDE M. CHAFFMAN</b>		2. DATE AND HOUR OF DEATH <b>JAN 17, 1972</b>   <b>5:15 A</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b> <b>35 BALTIMORE, MD 21205</b>				A. STATE <b>MARYLAND</b>		B. COUNTY <b>908</b>	
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>604 GUTMAN AVE</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>	8. DATE OF BIRTH <b>09-13-87</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown Frazze</b>				14. MOTHER'S MAIDEN NAME <b>Mary Camp</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-14-8166</b>		17. INFORMANT ADDRESS <b>Willard F. Chaffman, 3332 Paine St.</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>482.91</b> <b>Respiratory Arrest</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Pneumonia, Chronic</b>				(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia, Chronic</b>			
				(C) _____			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>2/1</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/9</b> 19 <b>72</b> to <b>1/17</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>5:20 PM 1/17</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>R.D. Kramer MD</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>1/17/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBERT D. KRAMER</b>				23D. ADDRESS <b>M.D. DEGREE THE JOHNS HOPKINS HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-20-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Staben</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>		ADDRESS	

THE JOHNS HOPKINS HOSPITAL

1913-1914

Harvard

Harvard

THE JOHNS HOPKINS HOSPITAL

THE JOHNS HOPKINS HOSPITAL

THE JOHNS HOPKINS HOSPITAL

THE JOHNS HOPKINS HOSPITAL

K-610

72 00588

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00588

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>RUTH A. KRAPP</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 16 1972 11 a</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>2202 Pinewood Ave. Apt. 4C</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 16 1972 11 a</b>	
6. SEX <b>female</b>		7. RACE <b>white</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>Sept. 16, 1910</b>		10. AGE (In years last birthday) <b>61</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Beck</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2747</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Johanna ?</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>213-03-3655</b>		18. INFORMANT <b>August C. Krapp,</b>	
19. CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>1-17-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-20-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Parkwood</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Leonard J. Ruck, Inc., 5305 Harford Rd.</b>	
25C. FUNERAL DIRECTOR		ADDRESS	

75 11/18

75 11/18

10.10.1910

William Beck

U.S.A.

John

John

11-05-1910 Annual U. S. Census

11-05-1910 Annual U. S. Census

MAILED

1-20-75

1-20-75

1-20-75

1-20-75

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00589		REG. NO. 72 00589	
BIRTH NO. <b>M-235</b>		72 00589		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>CHARLES<sup>A</sup> McDaniel SR.</b>				2. DATE AND HOUR OF DEATH <b>1-17-72 7:55 AM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>CECIL</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b> BALTIMORE, MD 21205				C. CITY OR TOWN <b>RTSTNG SUN</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
				E. STREET AND NUMBER <b>RT # 1</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07-19-23</b>		9. AGE (In years last birthday) <b>48</b>	If Under 1 Tr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>XRAY TECH.</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>GOVT.</b>		11. BIRTHPLACE (State or foreign country) <b>MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>JOSEPH MCDANIEL</b>				14. MOTHER'S MAIDEN NAME <b>LILLI STMPKINS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES WW 2</b>				16. SOCIAL SECURITY NO. <b>217-12-7050</b>		17. INFORMANT <b>BETTY JANE McDaniel</b> ADDRESS <b>RISING SUN, MD</b>	
18. <b>20001</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIO-PULmonary arrest</b>		<b>5 min</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <b>Septicemia &amp; pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>3 1/2 days</b>	
				(C) <b>EC Ectopic Reticulum Cell Sarcoma</b>		<b>9 mos</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>JAN 13 19 72</b> to <b>JAN 17 19 72</b> that (I) (we) last saw the deceased alive on <b>JAN 17 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ( <u>did</u> ) (did not) view the body after death.							
23A. SIGNATURE <b>M. Horan M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>M. HORAN M.D.</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-20-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>ASBURY</b>		24D. LOCATION (City, town, or county) (State) <b>PORT DEPOSIT MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert Howard</b>		25C. FUNERAL DIRECTOR <b>TELE. FUNERAL HOME RISING SUN, MD</b>			

0870 55

0.00

0.00

0.00

07-12-70

x

0.00

0.00

0.00

0.00

0.00

0.00

0.00

0.00

0.00

0.00

0.00

0.00

0.00

0.00

0.00

0.00

0.00



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00590

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>(Julie) JULIA BREELEND</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> Month Day Year Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 16 1972 10:50p</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1002</b>		6. SEX <b>female</b> 7. RACE <b>negro</b> 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>6-22-07</b> 10. AGE (In years last birthday) <b>64</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
11. BIRTHPLACE (State or foreign country) <b>Ga.</b> 12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER <b>1304 Ashland Ave.</b>	
13. FATHER'S NAME <b>John Tolivaer</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Lula</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Lucille Meadows</b> ADDRESS <b>1046 Broadway</b>	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION, LAST.		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-17-72</b> ACTUAL SIGNATURE <b>Russell S. Fisher</b> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-20-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Wm C March</b>		ADDRESS <b>928 E. North Ave.</b>	

00000 55

00000 55

00000 55

00000 55

00000 55

00000 55

00000 55

00000 55

00000 55

00000 55

00000 55

00000 55

00000 55

00000 55

00000 55

00000 55

00000 55

00000 55

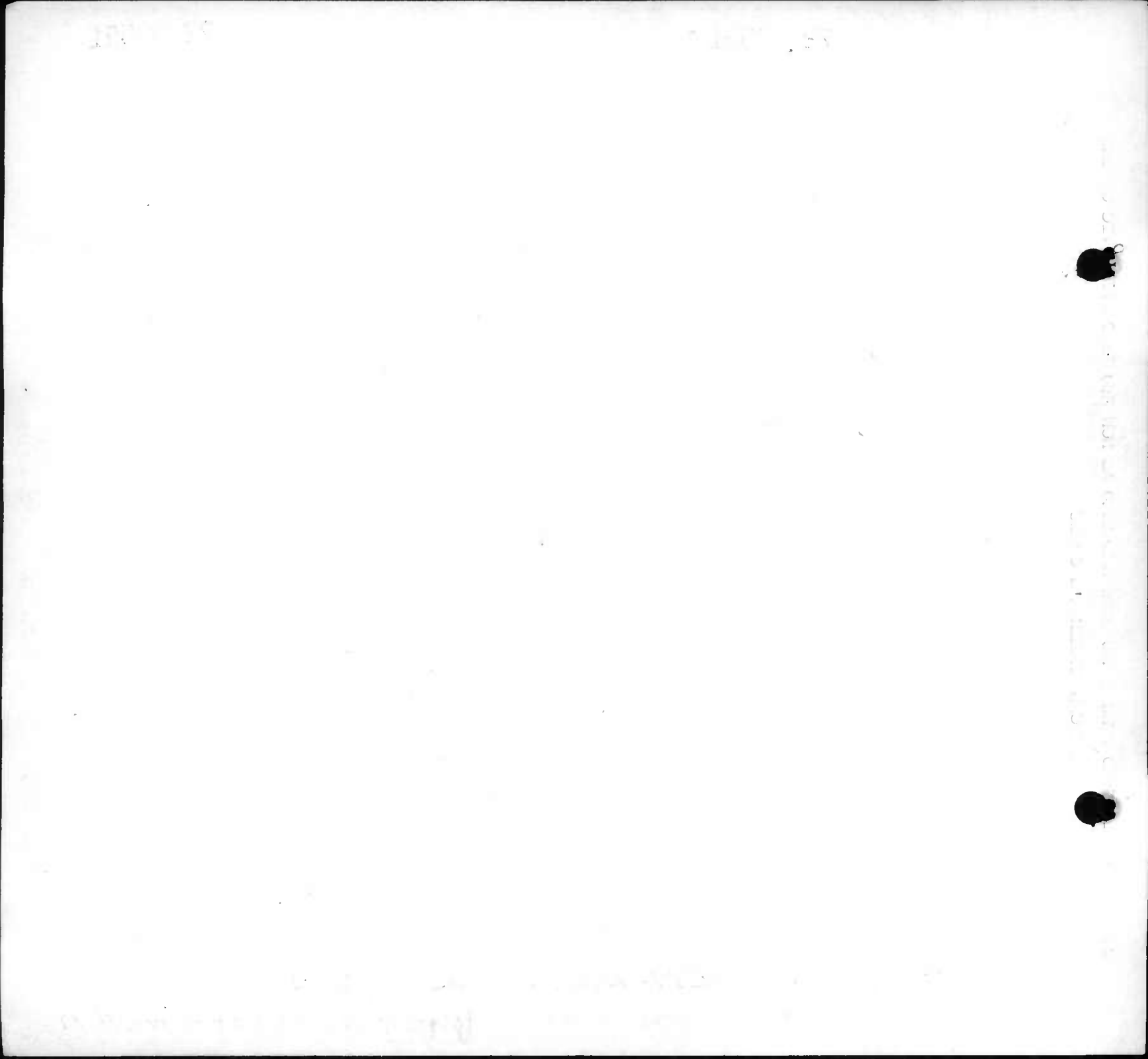
00000 55

00000 55

00000 55

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F 560 72 00591		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00591	
BIRTH NO. 70-06457		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Leonard Fenner		2. DATE AND HOUR OF DEATH 11/14/72 8:20 M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE Maryland B. COUNTY 2716			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 Johns Hopkins Hospital		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER 4505 Pimlico Road			
5. SEX M	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/14/70	9. AGE (In years last birthday) 19 1/2	10. If Under 1 Yr. Months Days Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Md	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Clayton Fenner			
14. MOTHER'S MAIDEN NAME Lorraine Harris		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT Parents			
18. 746.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: congenital heart disease (B) and mongolism DUE TO, OR AS A CONSEQUENCE OF: (C) possible infection		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1/14 1972 to 1/14 1972 that (I) (we) last saw the deceased alive on 1/14 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Mary Berakha MD		23B. DATE SIGNED 1/14/72		23C. PHYSICIAN'S NAME (Type) Mary Berakha MD	
23D. ADDRESS Johns Hopkins Hospital		23E. DATE 1-17-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. NAME OF CEMETERY or CREMATORY Mt Auburn Cem		24C. LOCATION (City, town, or county) (State) Baltimore Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 19 1972		25B. NAME OF REGISTRAR Robert E. Taylor, MD		25C. FUNERAL DIRECTOR WMC MARCH 928 E North Ave	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

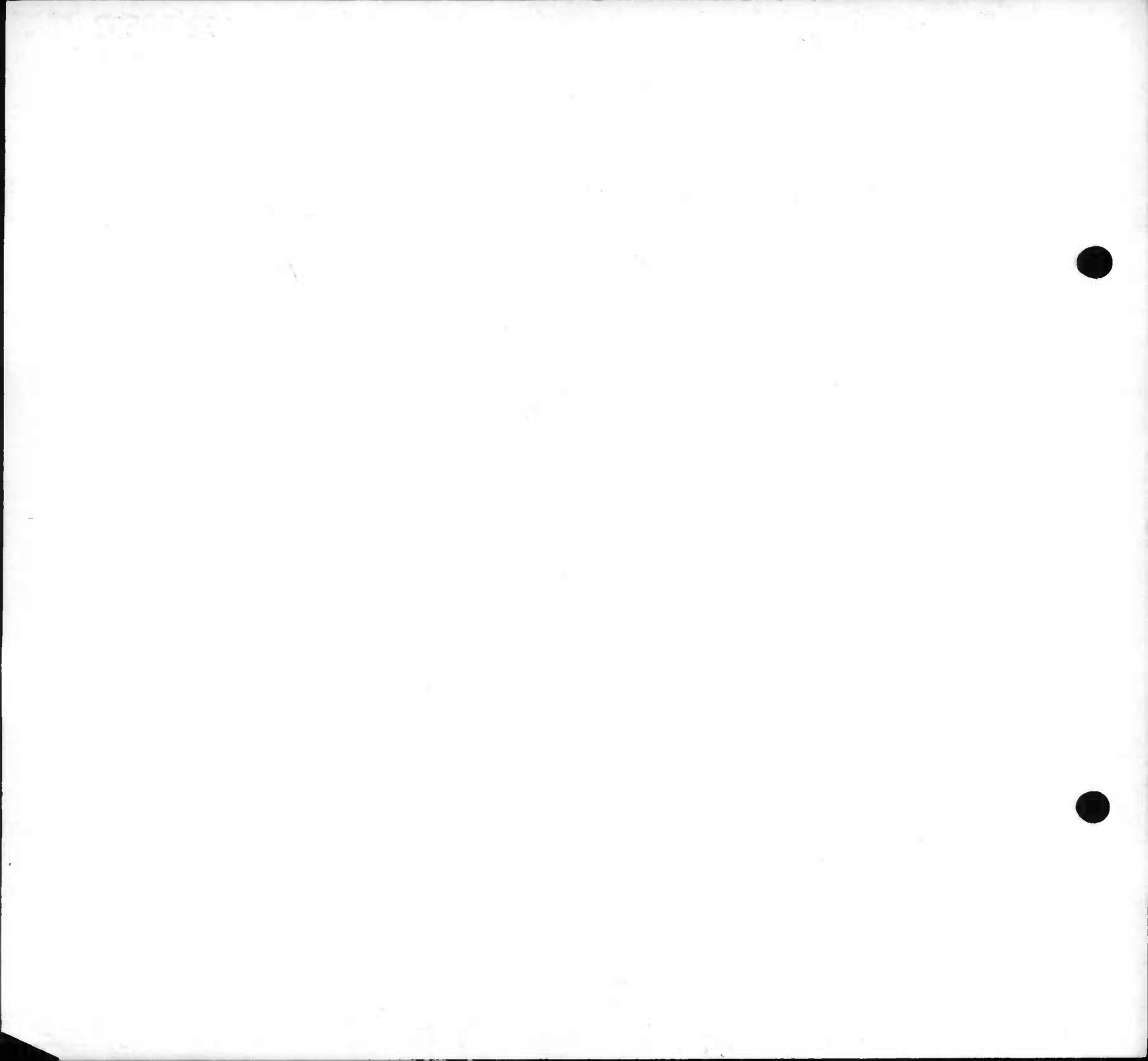
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00592	
BIRTH NO. 72 00592					
1. NAME OF DECEASED (Type or Print) <b>JOHNSON John</b>			2. DATE AND HOUR OF DEATH <b>January 14, 1972 9:30 a. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>906</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>23 Veterans Administration Hospital 3900 Loch Raven Blvd Baltimore, Maryland 21218</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>1609 E. 28th Street</b>					
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>8-30-90</b>	9. AGE (In years last birthday) <b>81</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Navy shipyard</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>	
13. FATHER'S NAME <b>George Johnson</b>		14. MOTHER'S MAIDEN NAME <b>Jane Willis</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 4-2-18 to 7-17-19</b>		16. SOCIAL SECURITY NO. <b>228-64-1304</b>		17. INFORMANT <b>Records</b> ADDRESS <b>VAH, 3900 Loch Raven Blvd., Balto., Md. 21218</b>	
18. <b>43691 + 185-X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>CUA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Abdominal aortic aneurism</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Ca Prostate, Cirrhosis, ASCVD</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>? 3 mo</b>		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 18, 1972</b> to <b>January 14, 1972</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 14, 1972</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.					
23A. SIGNATURE <b>Michael B. Pearlman</b>				23B. DATE SIGNED <b>1-14-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>MICHAEL B. PEARLMAN</b>				23D. ADDRESS <b>MD 3900 Loch Raven Blvd, Balto., Md. 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-18-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Baltimore Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Wm G March</b>		25C. FUNERAL DIRECTOR <b>928 E NORTH AVE</b>	

*[The following text is extremely faint and largely illegible due to the quality of the scan. It appears to be a multi-paragraph document, possibly a letter or a report, with several lines of text visible across the page. Some words like "Dear Sir" and "Yours faithfully" might be discernible in certain sections, but the majority of the content cannot be accurately transcribed.]*

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>6072 D0598 RS</b>	
C-250 72 00593		CERTIFICATE OF DEATH	
BIRTH NO.		2. DATE AND HOUR OF DEATH <b>01 00</b>	
1. NAME OF DECEASED (Type or Print) <b>CUCHMAN HERBERT</b>		17 JAN 72 11:35 A M.	
3. PLACE IN <b>BALTIMORE, MARYLAND</b> , WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>JOHN'S HOPKINS HOSPITAL</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>603</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>BALTIMORE</b>	
		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>208 N. Patterson Pk Ave.</b>	
5. SEX <b>M</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>6/1/00</b>
			9. AGE (in years last birthday) <b>71</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GUARD</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>DETECTIVE AGENCY</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTIMORE</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME <b>JUSIE BUTLER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>UNKNOWN</b>		16. SOCIAL SECURITY NO. <b>218-05-5341</b>	
17. INFORMANT <b>FRIEND - VIOLA JULIUS</b>		ADDRESS	
18. <b>41241</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenic, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(A) IMMEDIATE CAUSE <b>Ventricular standstill</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>30 min</b>	
(B) <b>atherosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>&gt; 30 yrs</b>	
(C) <b>pneumonia</b>		<b>~ 2 weeks</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12 JAN 1972</b> to <b>17 JAN 1972</b> that (I) (we) lost saw the deceased alive on <b>17 JAN 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Herman A. Schwitzer</b>		23B. DATE SIGNED <b>17 JAN 72</b>	
23C. PHYSICIAN'S NAME (Type) <b>HERMAN A. SCHWITZER MD</b>		23D. ADDRESS <b>JOHN'S HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Beth MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Wm E. March</b>	
25C. FUNERAL DIRECTOR <b>928 E North Ave</b>		ADDRESS	

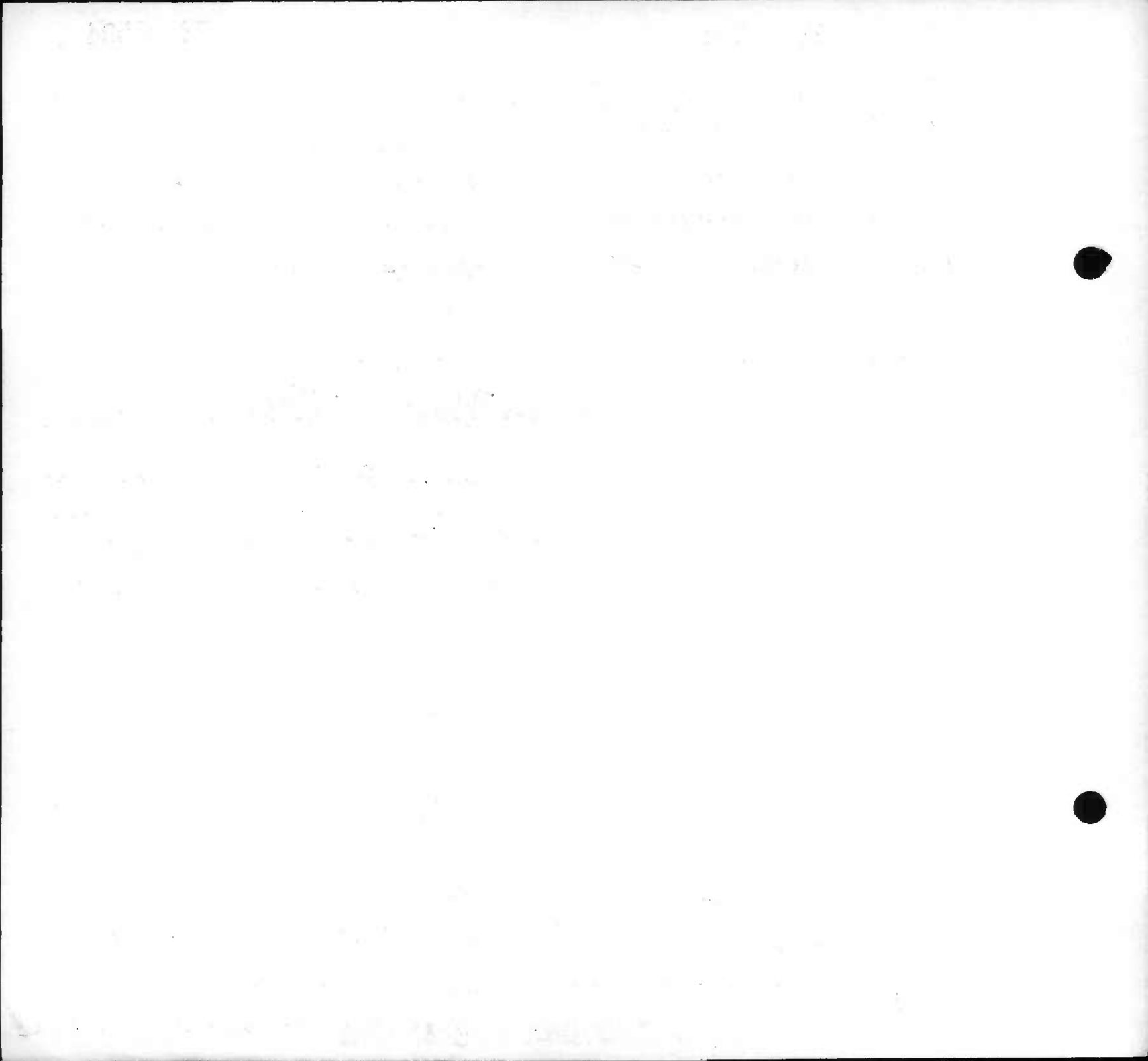




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

H. 626 1		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00594
BIRTH NO. 4626 72 00594				
1. NAME OF DECEASED (Type or Print) <u>Salomie (Hargrove) Hargrave</u>		2. DATE AND HOUR OF DEATH <u>1/16/72</u> <u>4:30</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Bolton Hill Nursing Home</u> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>1400 John Street</u> <u>Baltimore, Maryland.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1203</u>		
5. SEX <u>Female</u>		6. RACE <u>Black</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Georgia</u>
13. FATHER'S NAME <u>Seaborn THORNTON</u>		14. MOTHER'S MAIDEN NAME <u>CHARITY</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>237-22-9168</u>		17. INFORMANT <u>James Swilling</u> <u>2404 N. Calvert St.</u> ADDRESS <u>BALTO.</u>
18. <u>I</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF: <u>Decubiti ulcers</u>		<u>Dec 1971</u>
		(B) <u>Antemortem Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>Dec 1971</u>
		(C) <u>Arteriosclerosis generalized</u>		<u>years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1/11</u> 19 <u>72</u> to <u>1/16</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/16</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>1/17/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>ANCAN H. MARCH MD</u>		23D. ADDRESS <u>26 Reed St</u> <u>BALTO MD</u>		
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-19-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Auburn Cem</u>
24D. LOCATION <u>BALTO MD.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1972</u>		
25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Wm. C. MARCH</u> ADDRESS <u>928 E North Ave</u>		



R-400

72 00595

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00595

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Wilbur F. Ruhl</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> 1 18 72 M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bon Secours Hospital (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 18 72 11:45 a. M.	
6. SEX <b>male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>12/14/11</b>		10. AGE (In years last birthday) <b>60</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>—</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>	
15. MOTHER'S MAIDEN NAME <b>—</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>212-10-6081</b>		18. INFORMANT <b>Caroline Ruhl</b>	
19. CAUSE OF DEATH <b>412.4</b>		ADDRESS <b>31223</b>	

19. CAUSE OF DEATH <b>412.4</b>		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>1/19/72</b>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			

24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Mem. Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Hopewell Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Barber, M.D.</b>		25C. FUNERAL DIRECTOR <b>Geo. L. Schwab, Inc.</b>		ADDRESS <b>2101 Federal Ave. Balt. Md.</b>	

28000 ST

28000 ST

28000 ST

28000 ST

28000 ST

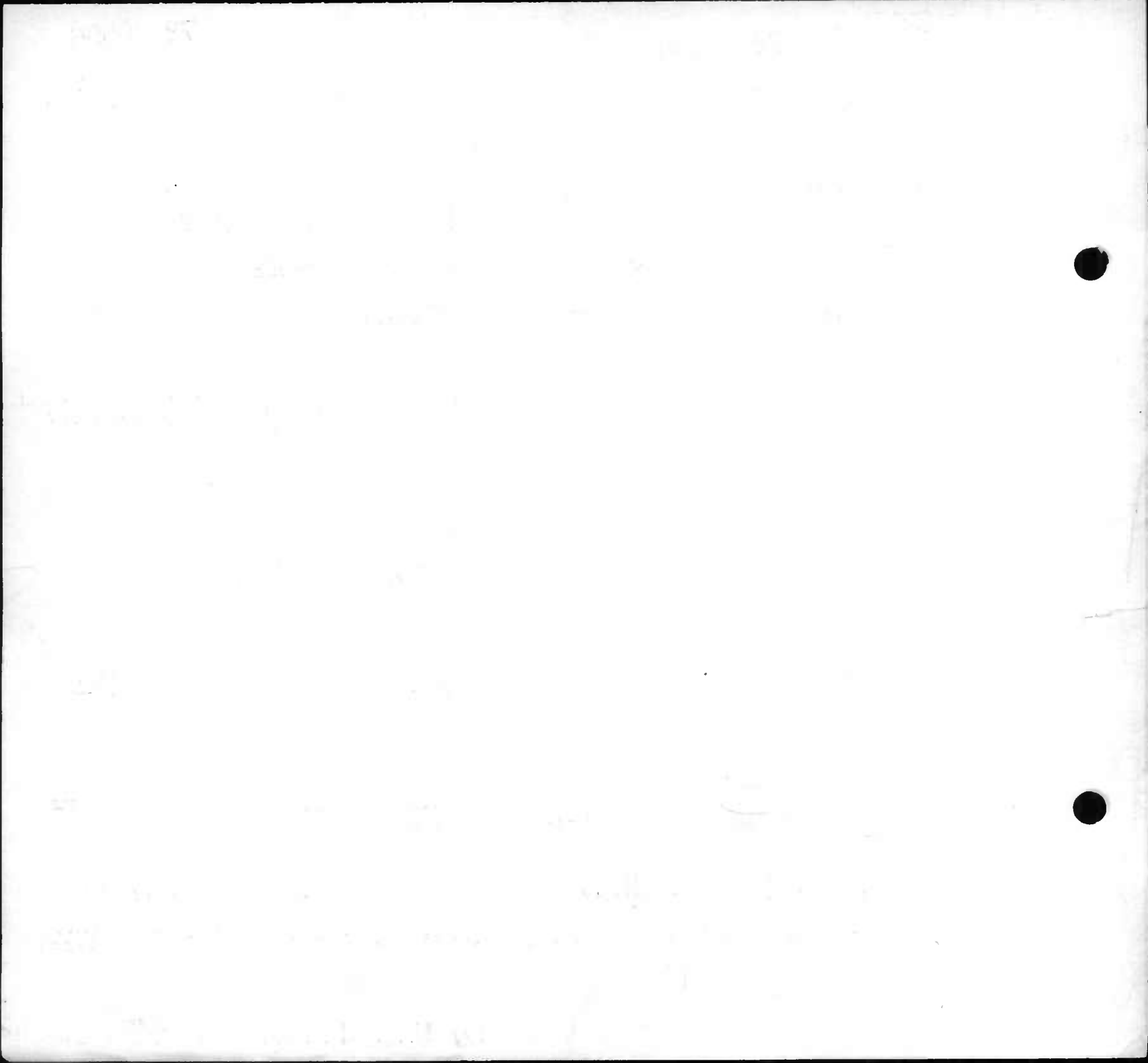
28000 ST

28000 ST

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 00596</span>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">72 00596</span>	
1. NAME OF DECEASED (Type or Print) <u>Viola Ross</u>			2. DATE AND HOUR OF DEATH <u>1-11-72</u> <u>8:00</u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>md. Gen. Hosp.</u> <u>48</u>			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>md.</u> B. COUNTY <u>1703</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>Whanvale St. 717</u>		
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Unknown</u>	9. AGE (In years last birthday) <u>~58</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>	11. BIRTHPLACE (State or foreign country) <u>Tenn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>?</u>			14. MOTHER'S MAIDEN NAME <u>?</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT <u>Willa Harrington</u> ADDRESS <u>717 W. Whanvale St. Balt-Md. 21217</u>		
18. <u>250.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary edema</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Renal failure</u> (C) <u>Diabetes mellitus</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>—</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>—</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>—</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>—</u>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>—</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>—</u>	
22. I certify that (I) <u>(this hospital)</u> attended the deceased from <u>1-10</u> 19 <u>72</u> to <u>1-11</u> 19 <u>72</u> that (I) <u>(we)</u> last saw the deceased alive on <u>1-11</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Arnold G. Alexander MD</u>			23B. DATE SIGNED <u>1-17-72</u>		23C. PHYSICIAN'S NAME (Type) <u>Arnold G. Alexander MD</u>
23D. ADDRESS <u>US 1 827 Linden Ave Balt. Md. 21201</u>					
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/18/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>St. Mary's</u>	
24D. LOCATION (City, town, or county) (State) <u>A.A. Cemetery, Maryland</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>1723 W. North Ave. Balt. Md. CARROLL</u>	



S530

1

72 00597

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 00597

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

SMITH LEAH

2. DATE AND HOUR OF DEATH

2:10 PM 1-14-72

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

46 Lutheran Hospital of Maryland

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

Maryland

1303

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☐NO ☐

E. STREET AND NUMBER

2533 Francis St. Balto Md 21211

5. SEX

F.

6. RACE

C.

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☐DIVORCED ☒

8. DATE OF BIRTH

4-29-03

9. AGE (In years  
last birthday)

68

If Under 1 Yr.

Months Days

If Under 24 Hrs.

Hours Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

William H. Leach

14. MOTHER'S MAIDEN NAME

Annie ?

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

21-16-3994

17. INFORMANT

(George  
Sond Smith)

ADDRESS

Same address

18.

445.91

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

Pulmonary embolism (?) Toxicemia

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

2° to gangrene @ Leg &amp; foot

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

-

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?

(If in Baltimore City, give exact location)

21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)☐21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-7-1972 to 1-14-1972  
that (I) (we) last saw the deceased alive on 1-14-1972 and that (in my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Amay M.D. MEMON M.D.

Attending ☐Med. Director ☐Staff Phys. ☒

23B. DATE SIGNED

1-14-72

23C. PHYSICIAN'S  
NAME (Type)

ABDUL MATID MEMON M.D.

23D. ADDRESS

Lutheran Hospital 730 Ashburton St Balto Md 21202

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-20-72

24C. NAME OF CEMETERY or CREMATORY

Mt Carmel Cmt

24D. LOCATION

(City, town, or county)

Balto Md

25A. DATE REC'D BY HEALTH DEPT.

JAN 19 1972

25B. NAME OF REGISTRAR

Robert E. Taylor M.D.

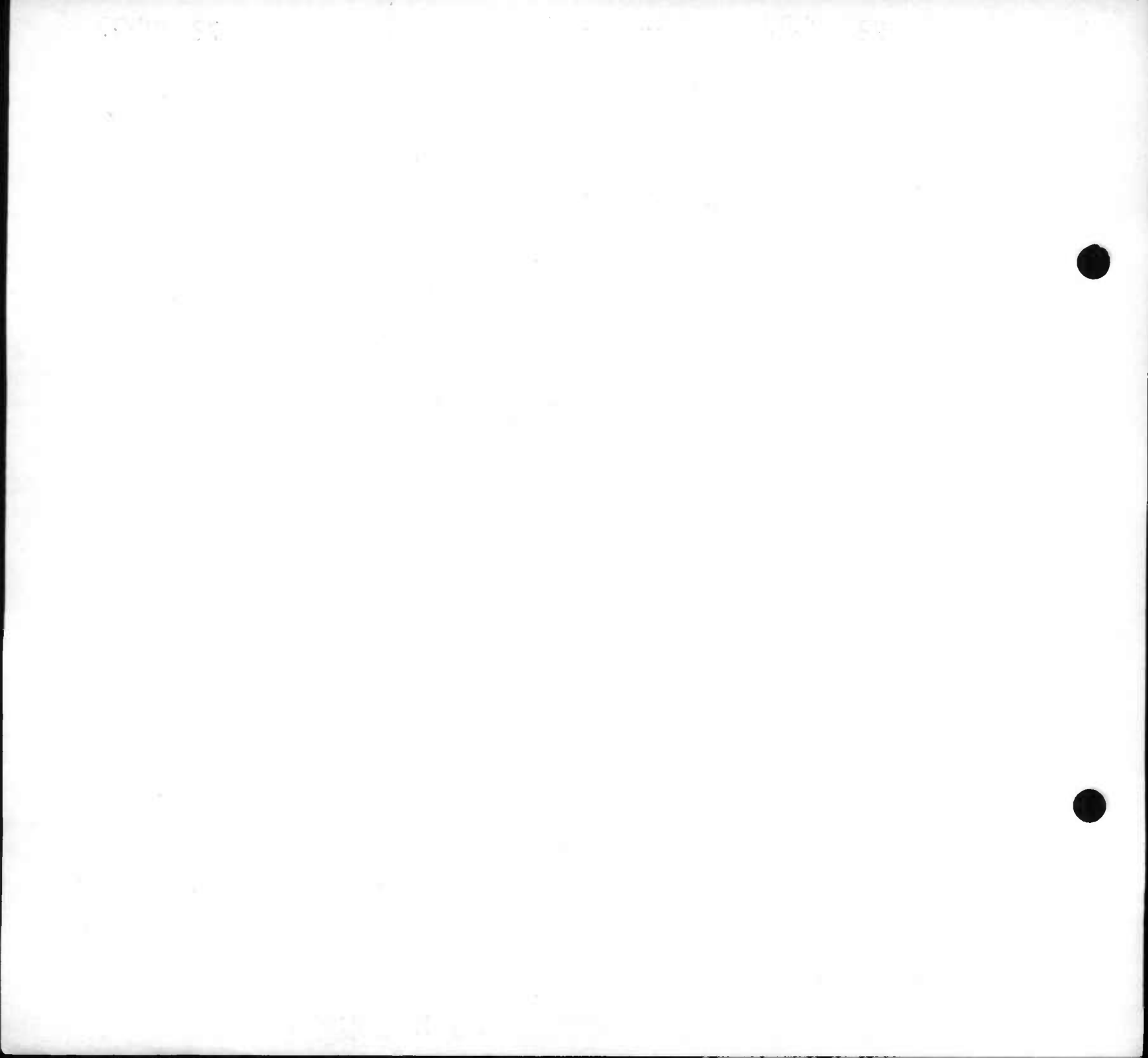
25C. FUNERAL DIRECTOR

J. E. Wilson

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00598	
72 00598		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <i>De Matas Paul</i>		2. DATE AND HOUR OF DEATH <i>Jan 11, 1972, 9:13 PM</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <i>43 South Baltimore General Hospital</i>		A. STATE <i>MD.</i> B. COUNTY <i>Baltimore</i>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>M</i> 6. RACE <i>W</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-26-00</i> 9. AGE (in years last birthday) <i>71</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country) <i>Philippines</i>	
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>unknown</i>		14. MOTHER'S MAIDEN NAME <i>unknown</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. <i>218-621988</i>	
17. INFORMANT <i>Harbor View Nursing Home</i>		ADDRESS <i>Harbor View Nursing Home</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>42R:3011/E893X</i> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Congestive Heart Failure 6 DAYS</i>	
ANTECEDENT CAUSES CHIEF IN ASST. MEDICAL EXAMINER, <i>14-72</i> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>ARTERIO SCLEROTIC HEART DISEASE</i>	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<i>15% SECOND DEGREE BURNS</i>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Nursing Home</i>	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>1213 LEXINGTON</i>		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <i>1-6-72 11:30</i>	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>climbs caught on fire while</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>1-5-72</i> 19 to <i>1-11-72</i> 19 that (I) (we) last saw the deceased alive on <i>1-11-72</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <i>Richard Siahaan</i>		23B. DATE SIGNED <i>1/11-72</i>	
23C. PHYSICIAN'S NAME (Type) <i>RICHARD SIAHAAN</i>		23D. ADDRESS <i>90 SO. BALTO GENITOSI, BALTO, MD.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-13-72</i>	
24C. NAME OF CEMETERY OR CREMATORY <i>St. Catharine</i>		24D. LOCATION (City, town, or county) (State) <i>Ad County MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Saffers, M.D.</i>	
25C. FUNERAL DIRECTOR <i>2830 N. 10th St</i>		ADDRESS <i>2830 N. 10th St</i>	

Adm. 8/27/70 back

212 Chancy Rd 21218

cod. d 10 H.H. 7011-55

ET

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 00599

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 00599

BIRTH NO. 72 00599		2. DATE AND HOUR OF DEATH 11/13/72 2:45 PM	
1. NAME OF DECEASED (Type or Print) <b>BANKS GENEVA</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Provident Hospital Complex</b> <b>39</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2406 Druid Hill Ave. 1303</b>	
5. SEX <b>Female</b>	6. RACE <b>Black</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/25/93</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>78</b>
11. BIRTHPLACE (State or foreign country) <b>Balto. Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-14-0673</b>	
17. INFORMANT <b>Charles Banks</b>		ADDRESS <b>2406 Druid Hill Ave.</b>	
18. <b>486X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CONGESTIVE HEART FAILURE</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>R/O ASPIRATION PNEUMONIA.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>DEC 29 1971</b> to <b>JAN 13 1972</b> that (I) (we) last saw the deceased alive on <b>JAN 13 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Rayman G. Kelly</b> M.D. DEGREE		23B. DATE SIGNED <b>JAN 13 72</b>	
23C. PHYSICIAN'S NAME (Type) <b>RAYMAN, I. AILY</b> M.D. DEGREE		23D. ADDRESS <b>PROVIDENT HOSPITAL, INC</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-19-72</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt Auburn C.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto Md</b>
25A. DATE REC'D BY HEALTH DEPT <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Edwin 1000 Broadway</b>		ADDRESS	

10-12-1942 10-12-1942 10-12-1942

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 00600		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00600	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Stafford, ALBERT</u>		2. DATE AND HOUR OF DEATH <u>1/12/72</u> <u>8:45AM</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>JOHNS HOPKINS HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>704</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>819 N. WOLFE STREET</u>			
5. SEX <u>MALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>03/26/06</u>	9. AGE (In years last birthday) <u>66</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Musician</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>STAFFORD, DAVID</u>		14. MOTHER'S MAIDEN NAME <u>MILLER, MARY</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218 10 2080</u>		17. INFORMANT <u>Lilke Stafford Lome</u>	
18. <u>412.21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  1) This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause 1A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Hypertensive ASCVD</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>Aug</u> 19 <u>71</u> to <u>Sept</u> 19 <u>71</u> that (I) (we) last saw the deceased alive on <u>Sept</u> 19 <u>71</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>McKopper, MD</u>		23B. DATE SIGNED <u>1/14/72</u>		23C. PHYSICIAN'S NAME (Type) <u>MARTHA W. KOPPER, MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-18-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Int. Auburn Cem.</u>	
24D. LOCATION (City, town, or county) (State) <u>Balto</u> <u>MD</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1972</u>		25B. NAME OF REGISTRAR <u>James E. Scales, M.D.</u>	
25C. FUNERAL DIRECTOR <u>1000 Brandy Ln</u>		25D. ADDRESS			

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

1870

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00601	
72 00601		CERTIFICATE OF DEATH	
1. NAME OF DECEASED <i>James Fincher</i>		2. DATE AND HOUR OF DEATH <i>11/16/72 3:40 P.M.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>33 JOHNS HOPKINS HOSPITAL</i>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>1001</i> C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1051 CENTRAL AVE</i>	
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>11/10/27</i>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (in years last birthday) <i>44</i>
11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>FINCHER, JOHN</i>		14. MOTHER'S MAIDEN NAME <i>CROMWELL, EVA.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Edith Summerville</i>		ADDRESS <i>1054 E Pratt St</i>	
18. <i>482.31</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <i>Cardiac Arrest</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <i>Staphylococcal Pneumonia</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>1-11</i> 19 <i>72</i> to <i>1-16</i> 19 <i>72</i> that (I) ( <del>we</del> ) last saw the deceased alive on <i>1-16</i> 19 <i>72</i> and that (in my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.			
23A. SIGNATURE <i>J. Harold Helderman, MD</i>		23B. DATE SIGNED <i>11/16/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>J. HAROLD HELDERMAN MD</i>		23D. ADDRESS <i>John Hopkins Hosp.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-21-72</i>	
24C. NAME OF CEMETERY or CREMATORY <i>Mt Calvary Cmt</i>		24D. LOCATION (City, town, or county) (State) <i>Adel County Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, RD 0</i>	
25C. FUNERAL DIRECTOR <i>Edith Summerville</i>		ADDRESS <i>1054 E Pratt St</i>	

11-11

11-11



72 00602

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00602

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Goley Johnson</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>101 Kane Street, in field</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 12, 1972</b> Hour M. <b>8:30 A.</b>	
6. SEX <b>Male</b>		8. MARried <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>Negro</b>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Dec 10 1907</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) <b>65</b>		E. STREET AND NUMBER <b>? 1811 Rutland rd</b>	
11. BIRTHPLACE (State or foreign country) <b>A. A County Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Edward Johnson</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
15. MOTHER'S MAIDEN NAME <b>Eleanor</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>210-10-0993</b>		18. INFORMANT <b>Kathy Addison Jones</b>	
19. <b>E 910.1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.) <b>Drowning</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Field</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>101 Kane Street</b>		22F. HOW DID INJURY OCCUR? <b>Drowned</b>	
22D. TIME OF INJURY (APPROX.) <b>Jan. 11/12-72 ?m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/13/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Buried</b>		24B. DATE <b>1-18-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mount Airy</b>		24D. LOCATION (City, town, or county) (State) <b>A. A County Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Charles</b>		25D. ADDRESS <b>1001 Brumfield</b>	

HRS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

72 00603

BIRTH NO.

72 00603

1. NAME OF DECEASED

(Type or Print)

NANNIE WILSON

2. DATE AND HOUR OF DEATH

1-11-72

4 a.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

UNION MEMORIAL HOSPITAL

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE

B. COUNTY

M.D.

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

920 CHANCEY AVENUE

5. SEX

F

6. RACE

N

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☒

DIVORCED ☐

8. DATE OF BIRTH

JULY 15, 1904

9. AGE (in years last birthday)

67 YRS

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Housewife

10B. KIND OF BUSINESS OR INDUSTRY

—

11. BIRTHPLACE (State or foreign country)

N. CAROLINA

12. CITIZEN OF WHAT COUNTRY?

AMERICAN

13. FATHER'S NAME

John Mills

14. MOTHER'S MAIDEN NAME

Unknown

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

—

17. INFORMANT

MARY STAVIS

ADDRESS

SAME

18. 486X1

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CARDIAC ARREST

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(B) DUE TO, OR AS A CONSEQUENCE OF:

PNEUMONIA

(C) DUE TO, OR AS A CONSEQUENCE OF:

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

0

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

—

20A. AUTOPSY? (Yes or No)

—

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

—

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

—

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

—

21C. WHERE DID INJURY OCCUR?

—

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

—

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

—

22. I certify that (I) (this hospital) attended the deceased from 1-9-72 to 1-11-72 that (I) (we) last saw the deceased alive on 1-11-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Juan M. Calderon

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-11-72

23C. PHYSICIAN'S NAME (Type)

JUAN M. CALDERON

23D. ADDRESS

M.D.

UMH

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-12-72

24C. NAME of CEMETERY or CREMATORY

Mount Calvary Cmt

24D. LOCATION

—

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 19 1972

25B. NAME OF REGISTRAR

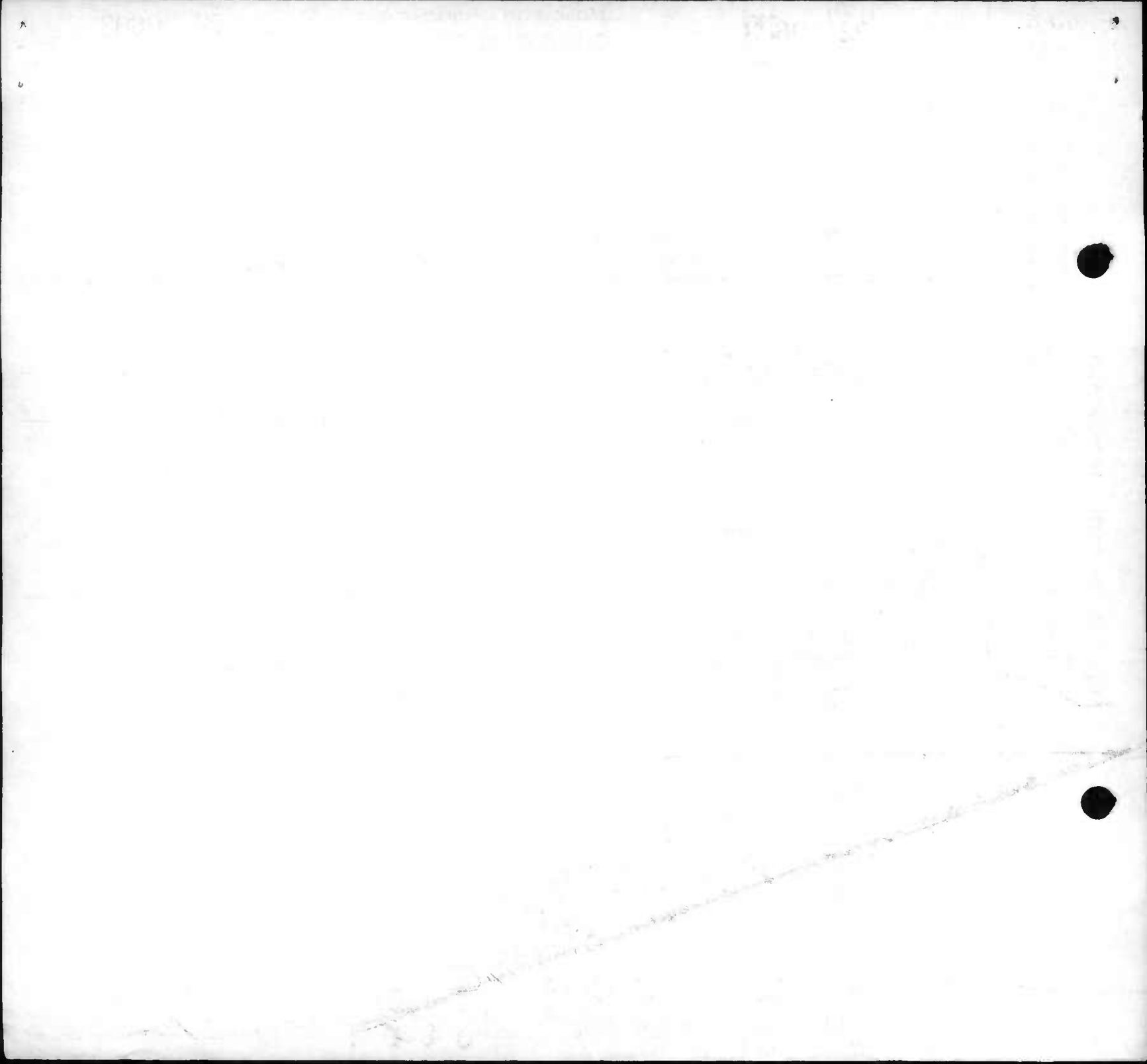
—

25C. FUNERAL DIRECTOR

—

ADDRESS

—



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

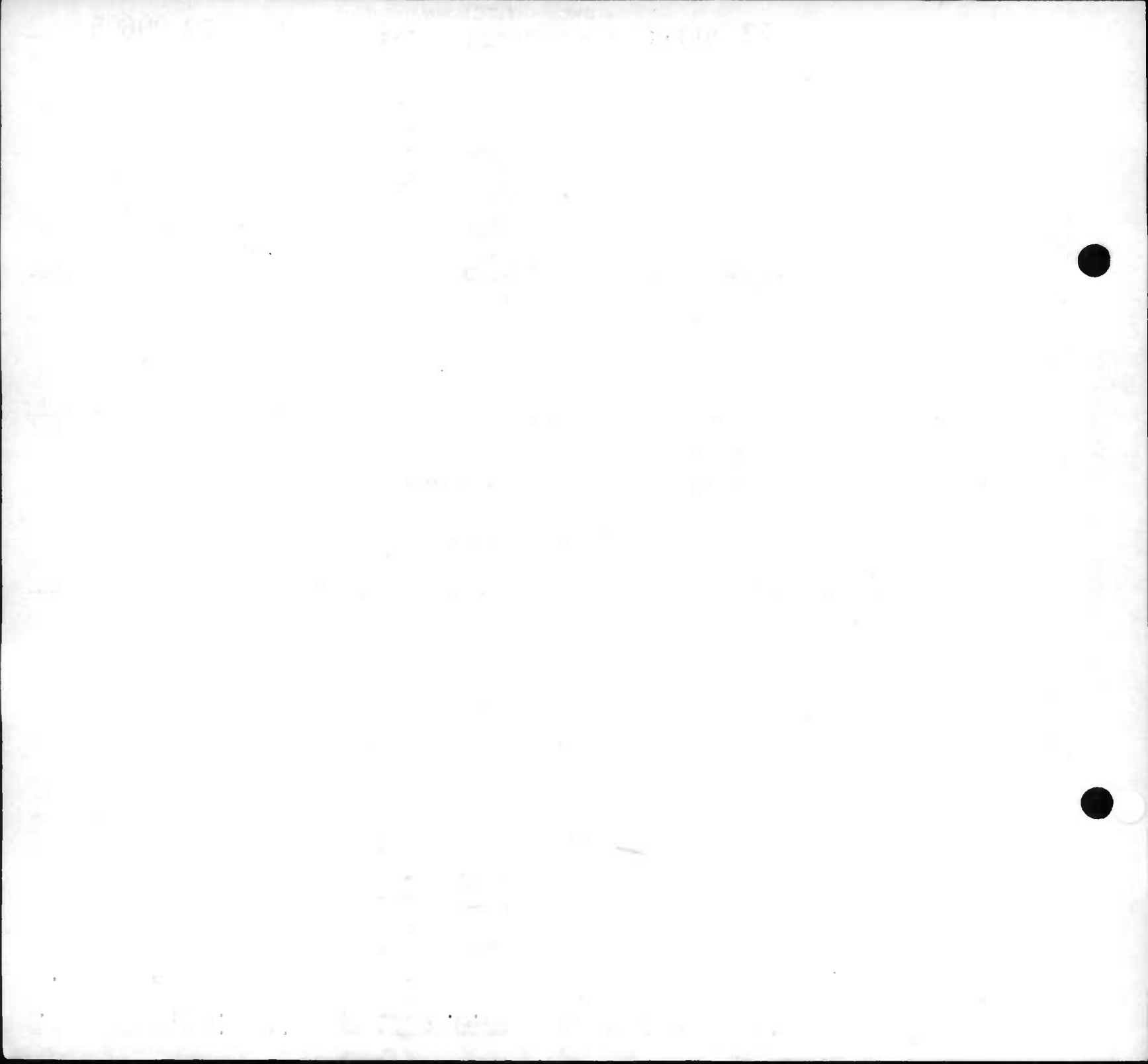
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00604	
BIRTH NO. 72 00604		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) DANIEL FISHER			2. DATE AND HOUR OF DEATH 1-14-72		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 35 CHURCH HOME & HOSPITAL			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY 301 C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 250 HERRING CT.		
5. SEX M	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-5-95	9. AGE (In years last birthday) 76	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired
11. BIRTHPLACE (State or foreign country) VIRGINIA			12. CITIZEN OF WHAT COUNTRY? U.S.A.		
13. FATHER'S NAME BENJAMIN FISHER			14. MOTHER'S MAIDEN NAME LIZZY MONKEY		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) M		16. SOCIAL SECURITY NO. 218-01-6412	17. INFORMANT Elderly Fisher Son		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Frequent PVC's			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from Jan. 12 19 72 to Jan. 14 19 72 that (I) (we) lost saw the deceased alive on Jan. 14 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Corazon Vergara M.D.				23B. DATE SIGNED 1-14-72	
23C. PHYSICIAN'S NAME (Type) CORAZON Z. VERGARA, M.D.				23D. ADDRESS 100 N. BROADWAY BALT. MD. 21231	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-19-72		24C. NAME OF CEMETERY OR CREMATORY Mt Airy Cmt	
24D. LOCATION (City, town, or county) (State) Baltimore City MD		25A. DATE REC'D BY HEALTH DEPT. JAN 19 1972			
25B. NAME OF REGISTRAR Robert E. Taylor M.D.		25C. FUNERAL DIRECTOR 1000 Broadway Ave			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00605</u>	
S-363		72 00605		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>STUART, JAMES KELLAS</u>		2. DATE AND HOUR OF DEATH <u>1-18-72</u> <u>9:10 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>THE UNION MEMORIAL HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1201</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>BROADVIEW APTS 1210 21218</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-08-87</u>	9. AGE (In years last birthday) <u>84</u>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED-V.P. OF BALTO.</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>SAVINGS BANK</u>		11. BIRTHPLACE (State or foreign country) <u>ENGLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>JAMES STEUART</u>			
14. MOTHER'S MAIDEN NAME <u>JENNIE E. N. KELLAS</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>MRS. FRED A. L. STEUART (SAME)</u>			
18. CAUSE OF DEATH <u>410.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</u> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>MIOCARDIAL INFARCTION</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) <u>NO</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from <u>1-10-72</u> to <u>1-18-72</u> that (I) (we) last saw the deceased alive on <u>1-18-72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. 23A. SIGNATURE <u>[Signature]</u> DEGREE 23B. DATE SIGNED <u>1-18-72</u> 23C. PHYSICIAN'S NAME (Type) <u>JULIO A. DEJO M.D.</u> DEGREE 23D. ADDRESS <u>THE UNION MEMORIAL HOSPITAL</u> 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Entombment</u> 24B. DATE <u>1/20/72</u> 24C. NAME of CEMETERY or CREMATORY <u>Lorraine Park Mausoleum</u> 24D. LOCATION (City, town, or county) (State) <u>Baltimore County, Md.</u> 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1972</u> 25B. NAME OF REGISTRAR <u>Robert J. Jenkins</u> 25C. FUNERAL DIRECTOR ADDRESS <u>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balto., Md. 21212</u>					

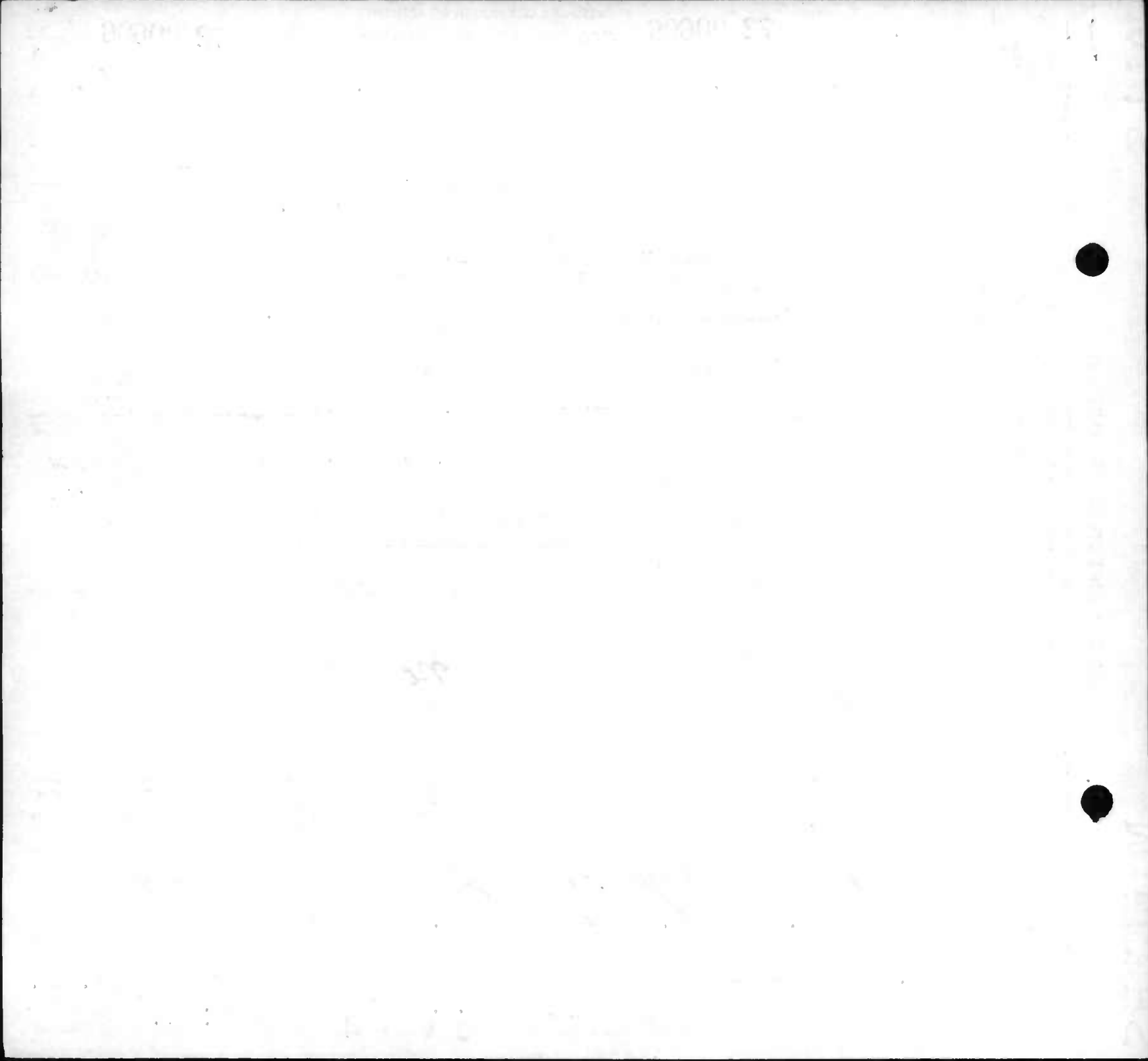




# FUNERAL DIRECTOR: IMPORTANT

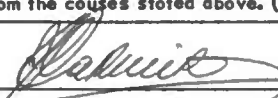
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

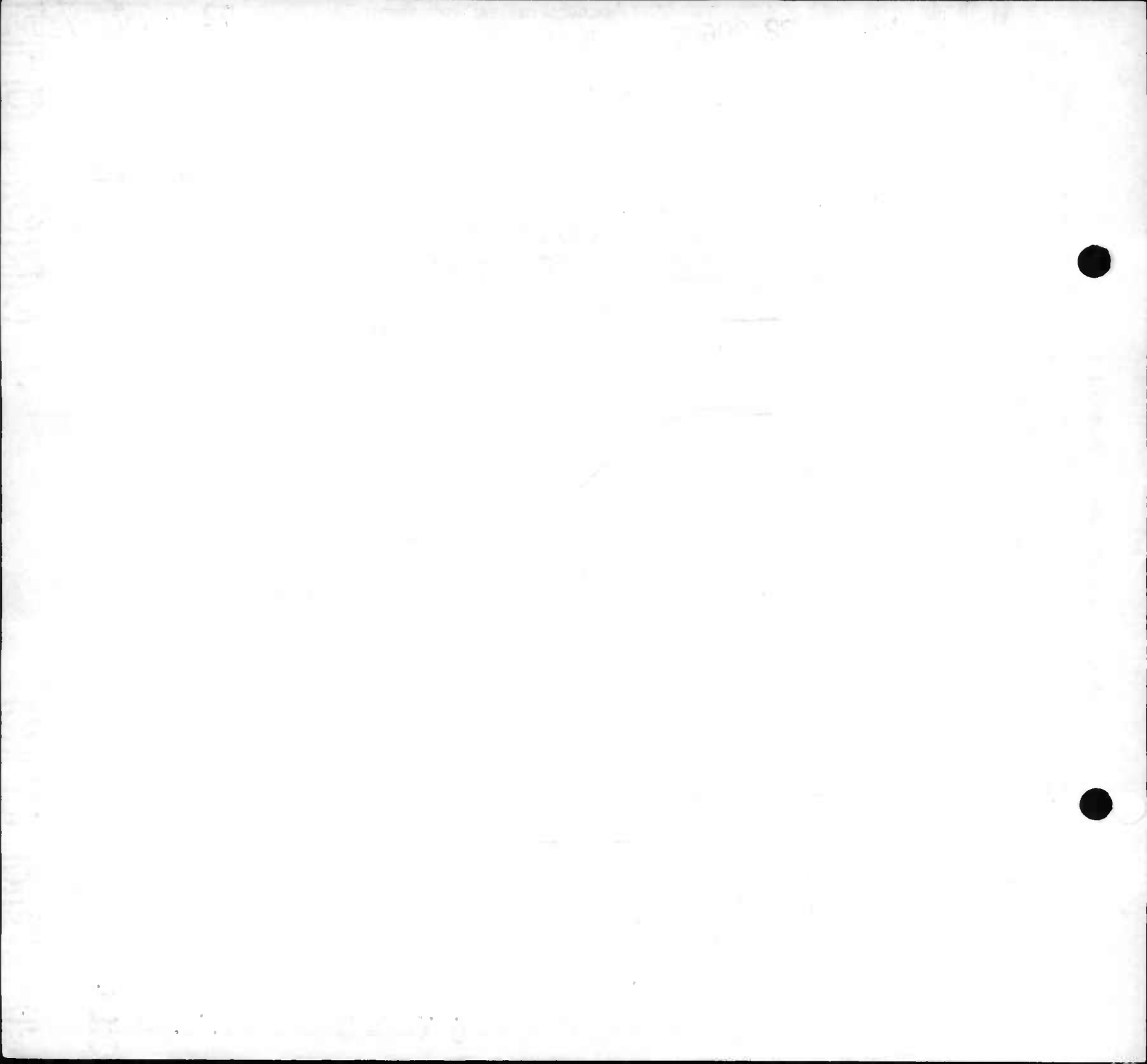
14-650		72 00606		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00606	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) Myrtle J. Horne				2. DATE AND HOUR OF DEATH Jan. 18, 1972 8 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY 2714			
FULL NAME OF HOSPITAL OR INSTITUTION 90		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) House in Pines-Belvedere		C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX F		6. RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10-22-1882	
9. AGE (In years last birthday) 89		10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Practical Nurse		10B. KIND OF BUSINESS OR INDUSTRY Nursing		11. BIRTHPLACE (State or foreign country) Suttersville, Pa.	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME George Stotler		14. MOTHER'S MAIDEN NAME Sara Foss		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No	
16. SOCIAL SECURITY NO. 216-22-7726		17. INFORMANT Mrs. Richard Horne		ADDRESS 21210 Woodlawn Road		18. CAUSE OF DEATH Pneumonia	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ASCVD ECVA		(B) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days Years	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from 10-12-1967 to 1-12-1972 that (I) (we) last saw the deceased alive on 1-18-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE R. K. Gundry M.D. DEGREE	
23B. DATE SIGNED 1-19-72		23C. PHYSICIAN'S NAME (Type) Dr. Richard K. Gundry		23D. ADDRESS 2 W. University Pkwy		24. BURIAL CREMATION, REMOVAL (Specify) Rem. Burial	
24B. DATE 1-21-72		24C. NAME of CEMETERY or CREMATORY Plum Creek		24D. LOCATION (City, town, or county) (State) Plum Boro Allegheny Co., Pa.		25A. DATE REC'D BY HEALTH DEPT. JAN 19 1972	
25B. NAME OF REGISTRAR Robert E. Sabers, M.D.		25C. FUNERAL DIRECTOR H.W. Jenkins & Sons Co.		ADDRESS 4905 York Rd. Balto., Md. 21212		26. 000004	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

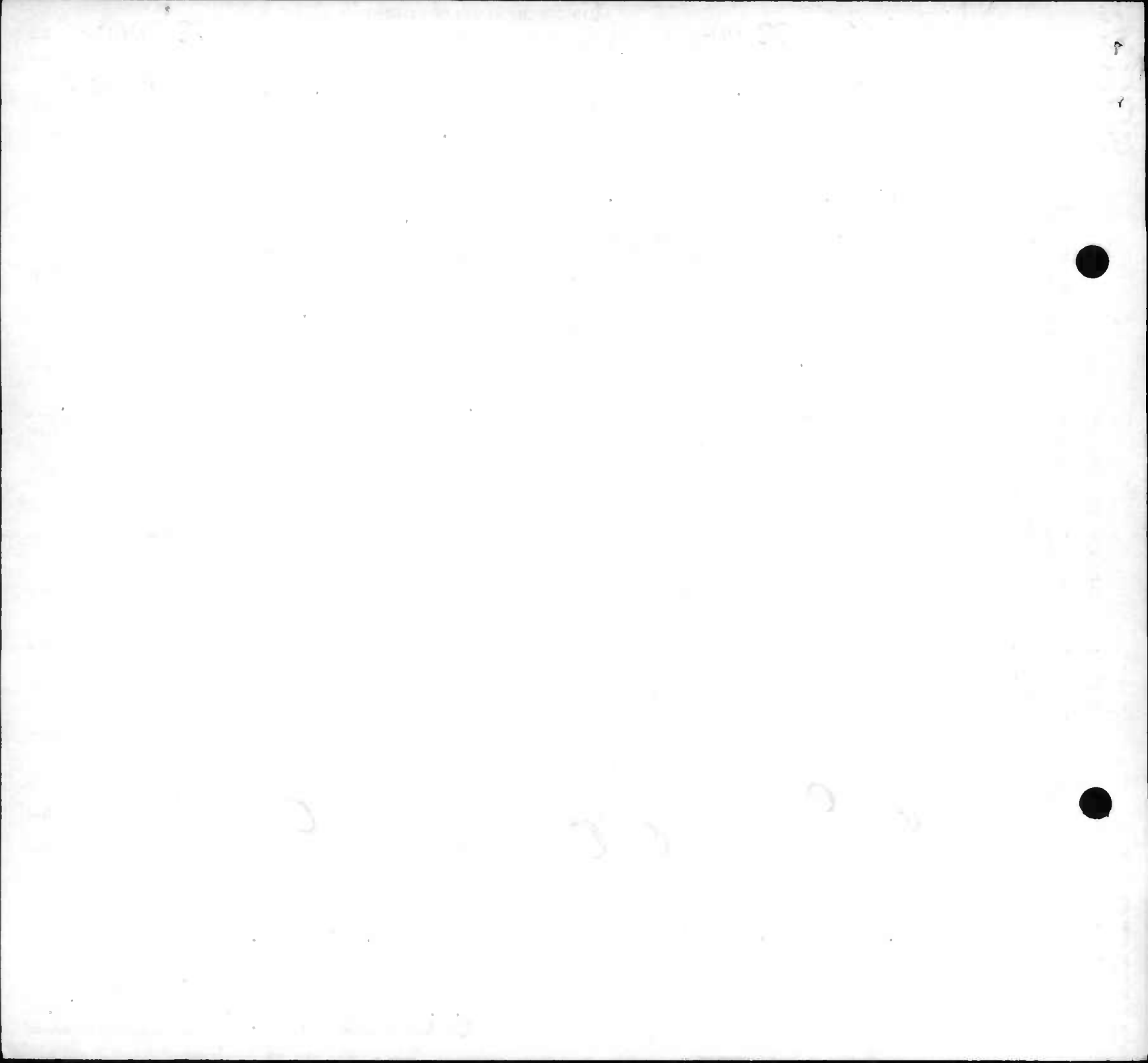
V-200 72 00607		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 100 607
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>EMMA B. VICK</b>		2. DATE AND HOUR OF DEATH <b>1/18/1972 10:15 P.M.</b>
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>908</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>UNION MEMORIAL HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <b>1901 HOMEWOOD AVE.</b>				
5. SEX <b>FEM</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/02/83</b>	9. AGE (In years last birthday) <b>88</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
13. FATHER'S NAME <b>CHARLES BULL</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MRS. D. F. CUTHBERT</b>
18. <b>154.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>DEPSIS</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>RECTAL CA</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>METASTATIC CA</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>RECTAL CA</b> (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <b>Dec 22, 1971</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>RECTAL CA</b>		20A. AUTOPSY (Yes or No) <b>NO</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that <del>(H)</del> (this hospital) attended the deceased from <b>11/13/91</b> 19 <b>72</b> to <b>1/18</b> 19 <b>72</b> that <del>(H)</del> (we) last saw the deceased alive on <b>1/18</b> 19 <b>72</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) <del>(did not)</del> view the body after death.				
23A. SIGNATURE 		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1/18/72</b>
23C. PHYSICIAN'S NAME (Type) <b>RENATO S. CARNEIRO</b>		23D. ADDRESS <b>334 Calvert St - Balto - Md</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Olivet</b>
24D. LOCATION <b>Baltimore Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>H. W. Jenkins &amp; Sons Co.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>4905 York Rd. Balto. Md. 21212</b>



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

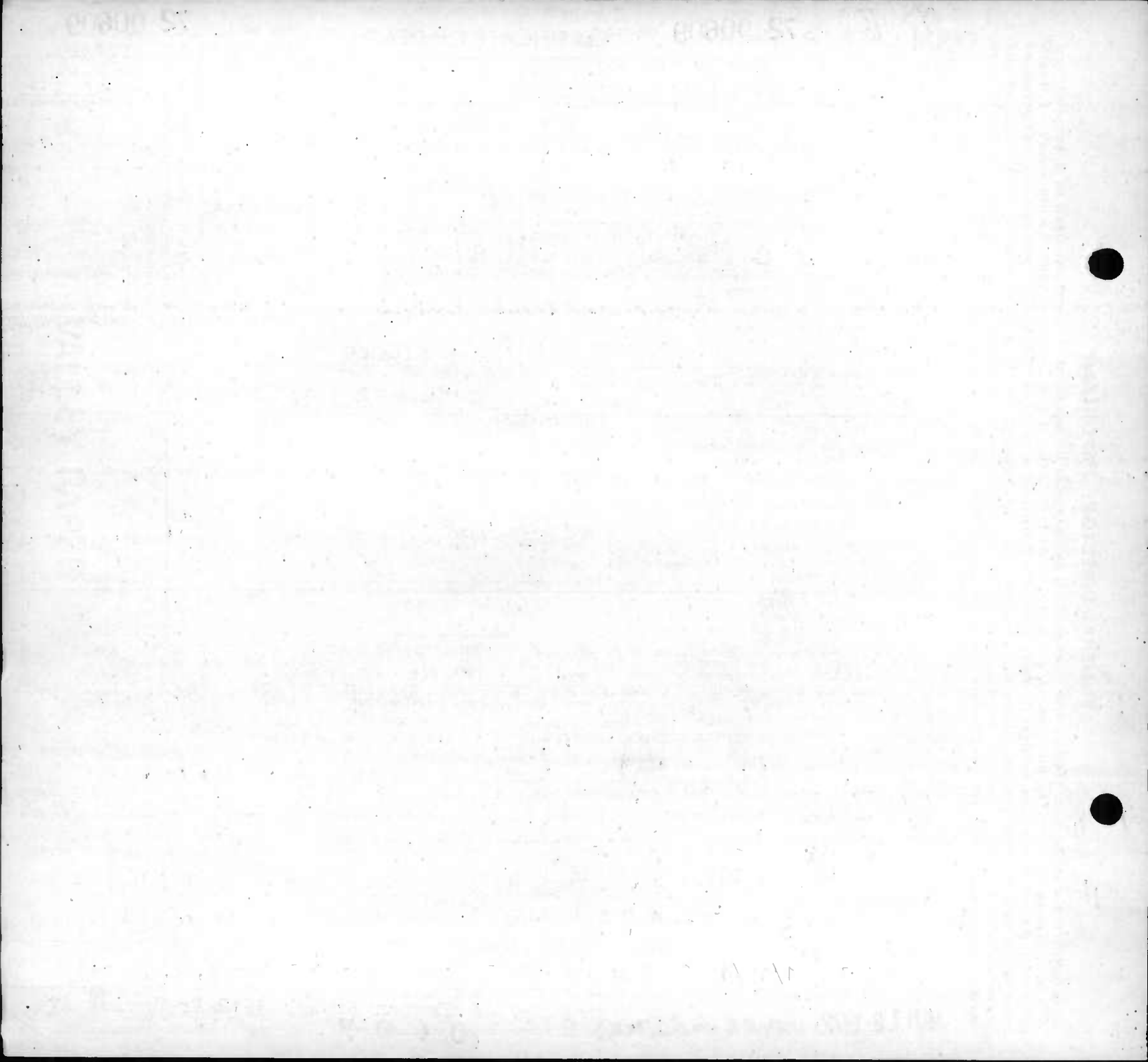
<p><b>5-341 72 00608</b></p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 00608</b></p>	
<p>BIRTH NO. <b>5-341</b></p>		<p>DATE AND HOUR OF DEATH <b>Jan. 16, 1972 8:30 P. M.</b></p>	
<p>1. NAME OF DECEASED (Type or Print) <b>Melitta R. Stalfort</b></p>		<p>2. DATE AND HOUR OF DEATH</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION <b>00 100 W. University Pkwy.</b></p>		<p>A. STATE <b>Md.</b> B. COUNTY <b>1201</b></p>	
<p>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION</p>		<p>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>E. STREET AND NUMBER <b>100 W. University Pkwy Apts 5C</b></p>	
<p>8. DATE OF BIRTH <b>10-30-1891</b> 9. AGE (In years last birthday) <b>80</b></p>		<p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b></p>	
<p>11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>	
<p>13. FATHER'S NAME <b>Henry S. Rippel</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Cornelia Rupple</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b></p>		<p>16. SOCIAL SECURITY NO. <b>220-44-2531</b></p>	
<p>17. INFORMANT <b>H. Alfred Stalfort</b></p>		<p>ADDRESS <b>21212 213 Goodale Rd.</b></p>	
<p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Parkinson Disease</b></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>	
<p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Small Arterio Sclerosis</b></p>	
<p>ANTECEDENT CAUSES</p>		<p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(C)</p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION <b>0</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <b>no</b></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (APPROX.)</p>	
<p>21E. INJURY OCCURRED</p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (1) (this hospital) attended the deceased from <b>1972</b> to <b>date</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</p>		<p>23A. SIGNATURE <b>Walter J. Baetjer</b></p>	
<p>23B. PHYSICIAN'S NAME (Type) <b>Dr. Walter J. Baetjer</b></p>		<p>23C. ADDRESS <b>1020 St. Paul St.</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>1-19-72</b></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>H.W. Jenkins Sons Co.</b></p>	
<p>25C. FUNERAL DIRECTOR ADDRESS <b>4905 York Rd. Baltimore, Md. 21212</b></p>		<p>25D. DATE SIGNED <b>Jan 18-72</b></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 00609	
1. NAME OF DECEASED (Type or Print) <b>MILLER - JOSEPH H</b>				2. DATE AND HOUR OF DEATH <b>1/16/72 12:45 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>South Baltimore General Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>21229</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3126 Stafford Street</b>			
5. SEX <b>M</b>	6. RACE <b>C</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/12/13</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Printer</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Betty Business Forms</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph</b>			14. MOTHER'S MAIDEN NAME <b>Veronica Sommer</b>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No.</b>		16. SOCIAL SECURITY NO. <b>25-07-1124</b>		17. INFORMANT <b>Elkal</b>		ADDRESS <b>3126 Stafford St. Balt. Md.</b>	
18. <b>16/2/11 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>will</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Malignant Pleural Effusion</b> (B) <b>Carcinoma of lungs</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			
MEDICAL CERTIFICATION 19A. DATE OF OPERATION <b>0 will</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>will</b>		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>will</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>will</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>will</b>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>will</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>will</b>			
22. I certify that (H) (this hospital) attended the deceased, from <b>1/10/72</b> 1972 to <b>1/16/72</b> 1972, that (I) (we) last saw the deceased alive on <b>1/16/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>R. Sirithara M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1/16/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>R. SIRITHARA M.D.</b>				23D. ADDRESS <b>South Baltimore General Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/19/1972</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher</b>		25C. FUNERAL DIRECTOR <b>G. Truman Schwab</b>		ADDRESS <b>3512 Frederick Ave.</b>	

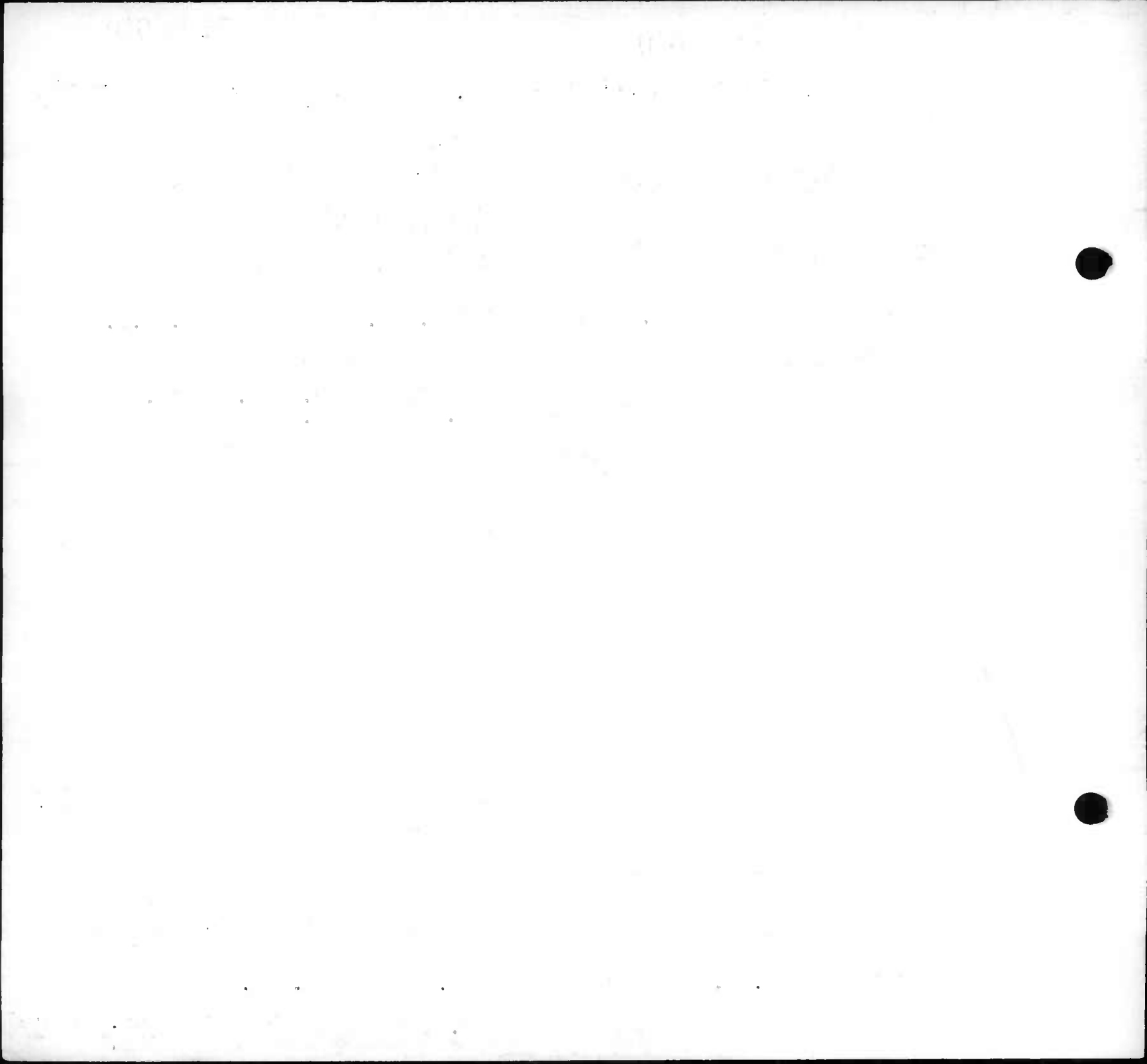




# FUNERAL DIRECTOR: IMPORTANT

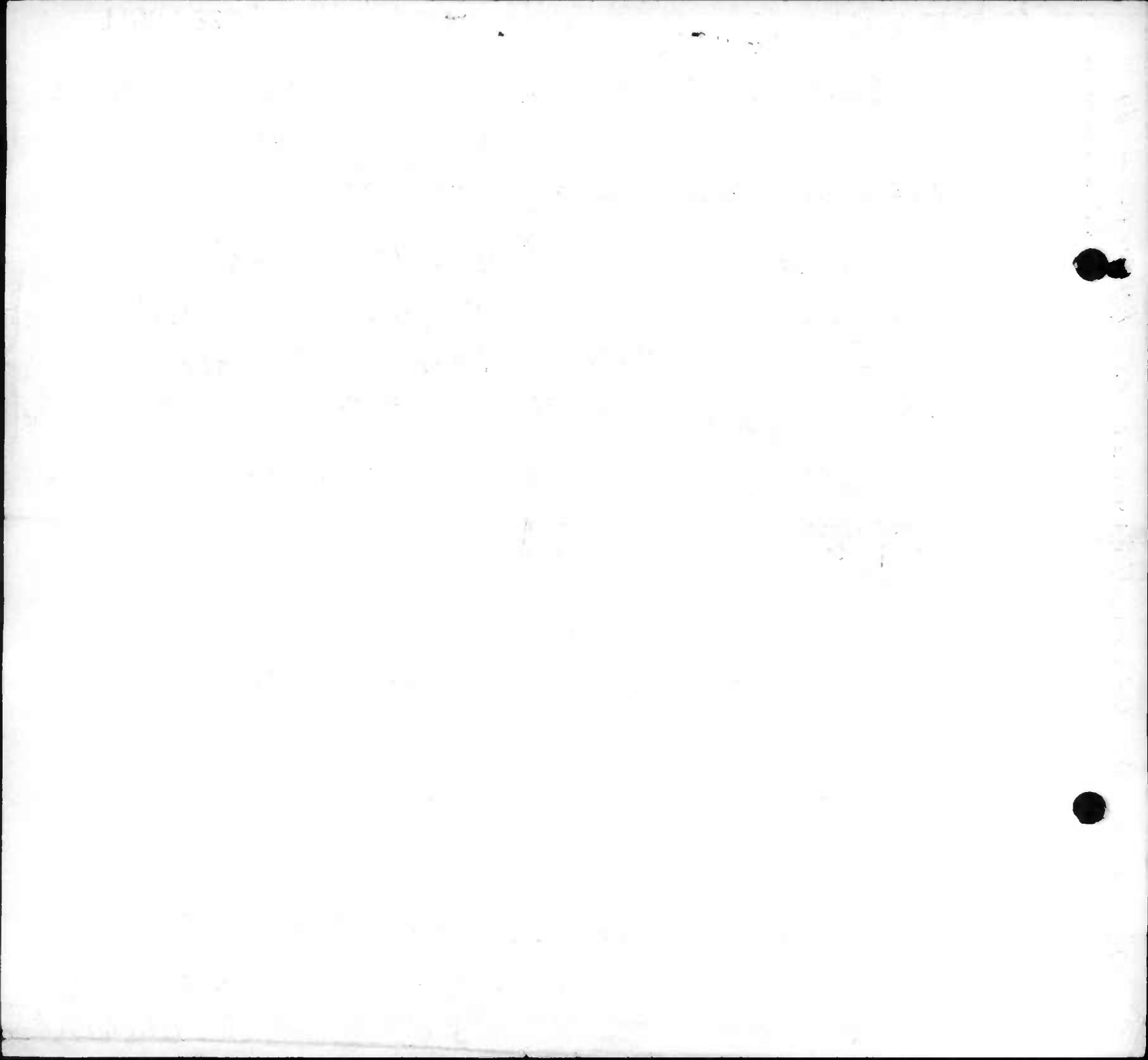
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-212		72 00610		BALTIMORE CITY HEALTH DEPARTMENT		X		72 00610	
BIRTH NO.		72 00610		CERTIFICATE OF DEATH		REG. NO.		72 00610	
1. NAME OF DECEASED (Type or Print) <b>MARGARET SIGAFOOSE H.</b>				2. DATE AND HOUR OF DEATH <b>1-16-72 7<sup>25</sup> P.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>BON SECOURS HOSP.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5918 BALTO. ST.</b>					
5. SEX <b>F</b>		6. RACE <b>WHITE</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-16-08</b>		9. AGE (In years last birthday) <b>63</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packer</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Dept. Store</b>		11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Julis Priebe</b>				14. MOTHER'S MAIDEN NAME <b>Maria Dudeck</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>215-18-0630</b>		17. INFORMANT <b>Mr. Charles B. Sigafoose</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE MYOCARDIAL INFARCTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ASCVD</b>				CAUSE OF DEATH <b>ACUTE MYOCARDIAL INFARCTION</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>HOURS</b> <b>YEARS</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>1-16-72</b> to <b>1-16-72</b> that (I) (we) last saw the deceased alive on <b>1-16-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Oscar E. Ferdinandini M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1-16-72</b>			
23C. PHYSICIAN'S NAME (Type) <b>OSCAR E. FERNANDINI M.D.</b>				23D. ADDRESS <b>2025 W. FAYETTE ST. BALTO. MD.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan. 20, 1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>G. Truman Schwab</b>		ADDRESS <b>5151 Balto. National Pike</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		72 00611		REG. NO.	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Saunders John N.				1/14/72 18:30 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
THE JOHNS HOPKINS HOSP.				MD Calvert 5400			
C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
ISLAND CREEK				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
E. STREET AND NUMBER							
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH	
M		negro		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		05-12-14	
9. AGE (in years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
57		Oyster Shucker		Maryland		US	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Joseph Saunders				Henrietta Jackson			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
no				217-12-8844			
17. INFORMANT				ADDRESS			
Henrietta Saunders				Port Republic, Md.			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc., but means the disease, injury or complicating condition which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
CAUSE OF DEATH				18 hours			
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				Meningeal G.I. Bleeding			
(B) DUE TO, OR AS A CONSEQUENCE OF:							
(C) DUE TO, OR AS A CONSEQUENCE OF:							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Pneumonia Rt upper lobe unknown			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
1/14/72		GI Bleeding		YES		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?			
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I certify that (I) (this hospital) attended the deceased from 1/14/72 19 22 to 1/14 19 22 that (I) (we) last saw the deceased alive on 1/14 19 22 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
John M. Mazur M.D.				1/14/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JOHN M. MAZUR M.D.				THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)	
1-18-72		Brooks Church Cem.		Calvert Co.		Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 19 1972		Robert E. Taylor		Fairfax & Sons		Prince Frederick	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>MAX SELLERS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>33 Johns Hopkins Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 16 1972 8:41 PM.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>July 3, 1920</b>		10. AGE (In years last birthday) <b>51</b>	
11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Auto.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>yes</b>		17. SOCIAL SECURITY NO. <b>240-30-6010</b>	
18. INFORMANT <b>Mrs. Ruby Wright</b>		ADDRESS <b>1913 Aster Rd.</b>	
19. CAUSE OF DEATH <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-20-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Arlington National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Arlington Alexandria, Va.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Philip G. Crach</b>	
25C. FUNERAL DIRECTOR <b>1211 Chesaco Ave.</b>		ADDRESS <b>Balto Md</b>	

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

M-324

72 00613 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00613

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>JOHN HAROLD METCALF</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Hour	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 4501 Hamilton Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 15, 1972 4:40 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>March 3, 1952</b>		10. AGE (In years lost birthday) <b>19</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Harold Metcalfe</b>		14. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>902</b>	
15. MOTHER'S MAIDEN NAME <b>Virginia Childress</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 26 Mar 69-21 Sep 70</b>	
17. SOCIAL SECURITY NO. <b>218-58-4387</b>		18. INFORMANT <b>Virginia Buchanan</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocarditis</b> 218-CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION <b>1</b>		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME (Month) (Day) (Year) (Hour) (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic</b> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/15/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b>		24B. DATE <b>January 18, 72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Dorsey Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Dippel Bro's Inc.</b>		ADDRESS <b>7110 Belair Road 21206</b>	

2-4-1972 - Form - Completion of cause of death on a pending medical examiner death certificate

Peter Lipkovic, M.D.

HRS



THE BODY OF [REDACTED] THOMAS CLARKE HAS BEEN RELEASED ON APPROVAL BY  
[REDACTED] **FUNERAL DIRECTOR: IMPORTANT**

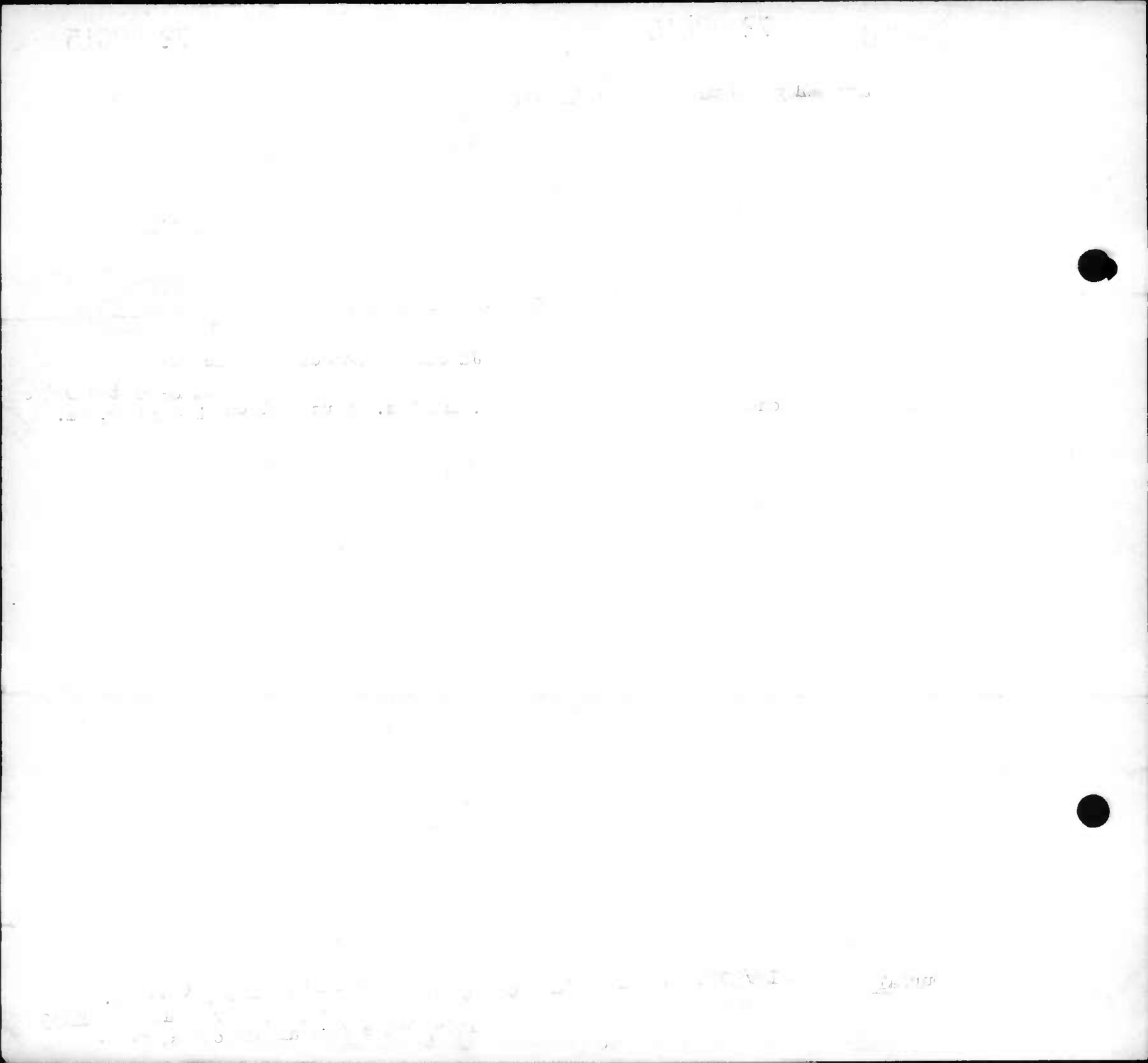
C-462		72 00614		BALTIMORE CITY HEALTH DEPARTMENT		X		REG. NO.		72 00614	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		5. AGE (In years last birthday)	
Clarke, Thomas		Clarke Thomas T.		1/14/72 11:55 pm		Johns Hopkins Hospital		Maryland		54	
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN		D. INSIDE CITY LIMITS?		E. STREET AND NUMBER		F. COUNTY	
Johns Hopkins Hospital				California		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rte 2 Box 196		STANLEY	
6. SEX		7. RACE		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. DATE OF BIRTH		10. AGE (In years last birthday)		11. BIRTHPLACE (State or foreign country)	
M		Cauc.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2-11-17		54		MARYLAND	
12. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		13. KIND OF BUSINESS OR INDUSTRY		14. BIRTHPLACE (State or foreign country)		15. CITIZEN OF WHAT COUNTRY?		16. FATHER'S NAME		17. MOTHER'S MAIDEN NAME	
WATERMAN		SELF EMPLOYED		MARYLAND		U.S.A.		ALEXANDER CLARKE		HATTIE JONES	
18. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		19. SOCIAL SECURITY NO.		20. INFORMANT		21. ADDRESS		22. CAUSE OF DEATH		23. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No		213-12-2899		MRS. GAYNE CLARKE		SAME AS #4		Cancer of Esophagus		6 hrs.	
24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		25. (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., but the disease, injury or complication which caused death.)		26. ANTECEDENT CAUSES		27. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		28. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		29. MEDICAL CERTIFICATION	
Cancer of Esophagus		Shock & massive GI bleeding		Intercostal Artery Hemorrhage		Cancer of Esophagus					
30. DATE OF OPERATION		31. CONDITION FOR WHICH OPERATION WAS PERFORMED		32. AUTOPSY (Yes or No)		33. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		34. DATE OF OPERATION		35. DATE OF DEATH	
3/14/72		Upper GI Hemorrhage		YES		yes		3/14/72		1-14-72	
36. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		37. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		38. WHERE DID INJURY OCCUR?		39. IF IN BALTIMORE CITY, GIVE EXACT LOCATION		40. TIME OF INJURY (Month) (Day) (Year) (Hour)		41. INJURY OCCURRED	
<input type="checkbox"/>				INJURY OCCURRED				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
<input type="checkbox"/>				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>							
22. I certify that (I) (this hospital) attended the deceased from		23. that (I) (we) lost saw the deceased alive on		24. and that in (my) (our) opinion death occurred on the date		25. and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		26. SIGNATURE		27. DATE SIGNED	
1-14-72		1-14-72		1-14-72				Randolph O. George, M.D.		1-14-72	
28. PHYSICIAN'S NAME (Type)		29. NAME OF CEMETERY OR CREMATORY		30. LOCATION		31. DATE OF BURIAL		32. NAME OF REGISTRAR		33. FUNERAL DIRECTOR	
Randolph O. George, M.D.		ST. JOHNS CEMETERY		HOLLYWOOD, MD		JAN 19 1972		John M. Welch		Leonardtown, MD	
34. DATE REC'D BY HEALTH DEPT.		35. NAME OF REGISTRAR		36. FUNERAL DIRECTOR		37. ADDRESS		38. DATE OF BURIAL		39. NAME OF CEMETERY OR CREMATORY	
JAN 19 1972		John M. Welch		Leonardtown, MD				1-14-72		ST. JOHNS CEMETERY	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-420 72 00615		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 72 00615	
BIRTH NO. 72-01576 Baby Boy		1. NAME OF DECEASED (Type or Print) Baby Boy Bryan DeLuca		2. DATE AND HOUR OF DEATH 1/14/1972 19:35 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital, Baltimore, 34 Maryland 21223		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Pa., Shrewsbury B. COUNTY ✓ 35 C. CITY OR TOWN Shrewsbury D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 14 Lexington Dr. 17361			
5. SEX Boy	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1-14-1972	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days If Under 24 Hrs. Min. - 30
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Baltimore, Maryland	
13. FATHER'S NAME August DeLuca, Jr.		14. MOTHER'S MAIDEN NAME Janeen DeLuca (Macken)			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. and Mrs. August DeLuca 14 Lexington Drive Shrewsbury, Pa.	
18. 776-91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) RESPIRATORY FAILURE ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF: (B) Prematurity DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 7:05 pm, 1-14-1972 to 7:35 pm 1-14-1972 that (I) (we) last saw the deceased alive on 1-14-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Piriya Pinit, M.D.		23B. DATE SIGNED 1-14-72		23C. PHYSICIAN'S NAME (Type) PIRIYA PINIT, M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/18/1972		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Cemetery	
24D. LOCATION (City, town, or county) (State) Woodlawn, Balto. Co., Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 19 1972		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR 8728 Liberty Road Loring Byers Funeral Directors, P. A.		25D. ADDRESS 21133			



1  
S-255

72 00616

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00616

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>BERNARD W. SCHUCHMANN Sr.</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>31 BALTO. CITY HOSPITAL</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 15, 1972 1:34 A.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>10-26-12</b>		10. AGE (In years last birthday) <b>59</b>	
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Bernard Schuchmann</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dept. of Education</b>	
15. MOTHER'S MAIDEN NAME <b>Unknown</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>213-07-3683</b>		18. INFORMANT <b>Bernard W. Schuchmann Jr.</b>	
19. <b>E890X1</b>		ADDRESS <b>4227 Springwood Ave</b>	
CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		Carbon monoxide poisoning and smoke inhalation (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>102 Fagley Street</b>		22D. TIME (Month) (Day) (Year) (Hour) (Approx.) <b>1-15-72 12:30 A.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject in housefire</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> EXAMINER'S NAME (Type)  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/15/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-18-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Gardens of Faith Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Farley Jr.</b>	
25C. FUNERAL DIRECTOR <b>John C. Miller Inc.</b>		ADDRESS <b>6415 Belair Rd. - 21206</b>	

72 00616

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

15-00000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 00617</u>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <span style="float: right;"><b>AGNES MARIE THIEL</b></span>				<b>2. DATE AND HOUR OF DEATH</b> <div style="display: flex; justify-content: space-between;"> <span><b>Jan. 13, 1972</b></span> <span><b>4:45 a. M.</b></span> </div>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <div style="display: flex; justify-content: space-between;"> <div> <b>FULL NAME OF HOSPITAL OR INSTITUTION</b>  <div style="font-size: 2em; margin-left: 10px;">00</div> </div> <div> <b>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</b>  <b>Argonne</b>  <b>L 1204 Argonne Drive</b> </div> </div>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <div style="display: flex; justify-content: space-between;"> <div> <b>A. STATE</b>  <b>Md., 21218</b> </div> <div> <b>B. COUNTY</b>  <div style="font-size: 2em; margin-left: 10px;">2759</div> </div> </div>			
<b>5. SEX</b> <div style="display: flex; justify-content: space-between;"> <span><b>female</b></span> <span><b>white</b></span> </div>				<b>6. RACE</b> <div style="display: flex; justify-content: space-between;"> <span><b>WIDOWED</b></span> <span><b>DIVORCED</b></span> </div>			
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> 				<b>8. DATE OF BIRTH</b> <b>8/14/29</b>			
<b>9. AGE</b> (In years last birthday) <b>42</b>				<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Photo Finisher</b>			
<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Binko Photo Lab.</b>				<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Md.</b>			
<b>12. CITIZEN OF WHAT COUNTRY?</b>				<b>13. FATHER'S NAME</b> <b>Joseph A. Binko</b>			
<b>14. MOTHER'S MAIDEN NAME</b> <b>Nellie T. Hughes</b>				<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)			
<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <b>Joseph C. Thiel, husband, above</b>			
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Pulmonary failure</b>				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 week</b>			
<b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Carcinomatosis</b>				<b>2 months</b>			
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>None</b>				<b>5 months</b>			
<b>19A. DATE OF OPERATION</b> <b>8/6/71</b>				<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>Carcinoma of endometrium</b>			
<b>20A. AUTOPSY?</b> (Yes or No) <b>No</b>				<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>			
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)				<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)			
<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)				<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)			
<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				<b>21F. HOW DID INJURY OCCUR?</b>			
<b>22. I certify that (I) (the doctor) attended the deceased from 8/5/71 to 1971, that (I) (we) last saw the deceased alive on 1/12/1972, and that in (my) (the physician's) death occurred on the date and hour and from the causes stated above. (I) (we) (did) (not) view the body after death.</b>							
<b>23A. SIGNATURE</b> 				<b>23B. DATE SIGNED</b> <b>1/13/1972</b>			
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Dr. Irvin Klemkowski</b>				<b>23D. ADDRESS</b> <b>2 E. Read St.</b>			
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Removal</b>				<b>24B. DATE</b> <b>1/17/72</b>			
<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Lorraine Mausoleum</b>				<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Md.</b>			
<b>25A. DATE AND TIME OF HEALTH DEPT. REGISTRATION</b> <b>JAN 19 1972</b>				<b>25B. NAME OF REGISTRAR</b> <b>Robert E. Jolly, M.D.</b>			
<b>25C. FUNERAL DIRECTOR</b> <b>Schimunek Funeral Home, Inc.</b>				<b>ADDRESS</b> <b>3331 Brehms Lane</b>			

75 00017

75 00017

75 00017

1. 1904 Christmas Dinner

2. 1905 Christmas Dinner

3. 1906 Christmas Dinner

4. 1907 Christmas Dinner

5. 1908 Christmas Dinner

6. 1909 Christmas Dinner

7. 1910 Christmas Dinner

8. 1911 Christmas Dinner

9. 1912 Christmas Dinner

10. 1913 Christmas Dinner

11. 1914 Christmas Dinner

12. 1915 Christmas Dinner

13. 1916 Christmas Dinner

14. 1917 Christmas Dinner

15. 1918 Christmas Dinner

16. 1919 Christmas Dinner

17. 1920 Christmas Dinner



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>5-520</b>      <b>72 00618</b></p> <p style="text-align: right;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p> <p style="text-align: right;">REG. NO. <b>72 00618</b></p>					
<p><b>BIRTH NO.</b></p>		<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>FRANCES Rose SIMMS</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>1-13-72</b>      <b>7:49</b> <small>A.M.</small></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>				<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b>      B. COUNTY <b>None</b></p>	
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <b>34 BON SECOURS Hospital</b> <b>2025 W. FAYETTE STREET</b> <b>Baltimore, MARYLAND</b></p>		<p><b>C. CITY OR TOWN</b> <b>Baltimore MD</b></p>		<p><b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/>      NO <input type="checkbox"/></p>	
<p><b>5. SEX</b> <b>F</b></p>		<p><b>6. RACE</b> <b>W</b></p>		<p><b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Cigar Maker</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Amorita Cigar Co</b></p>		<p><b>8. DATE OF BIRTH</b> <b>3/30/1895</b></p>	
<p><b>13. FATHER'S NAME</b> <b>Lissy</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b> <b>unknown</b></p>		<p><b>9. AGE</b> (in years last birthday) <b>76</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p><b>16. SOCIAL SECURITY NO.</b> <b>216-81-5954</b></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Czechoslovakia</b></p>	
<p><b>17. INFORMANT</b> <b>Elmer Alban, son, 3904 Pinewood Ave.</b></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b></p>		<p><b>19. DATE OF OPERATION</b> <b>1-12-72</b></p>	
<p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Does from negative bacteremic shock</b></p>		<p><b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Uremic blood infection + Diabetes Mellitus</b></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>	
<p><b>ANTECEDENT CAUSES</b> <b>ASCOD + ASHD + CHF</b></p>		<p><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b></p>		<p><b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b></p>	
<p><b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>					
<p><b>19A. DATE OF OPERATION</b> <b>1-12-72</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No) <input checked="" type="checkbox"/></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)</p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/>      Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from <b>1-7-72</b> to <b>1-13-72</b> that (I) (we) last saw the deceased alive on <b>1-13-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>					
<p><b>23A. SIGNATURE</b> <b>M. Achum MD</b></p>				<p><b>23B. DATE SIGNED</b> <b>1-13-72</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>MARCELINO F. BUBUNAE MD</b></p>				<p><b>23D. ADDRESS</b> <b>7935 PIPERS PARK FROM ROUTE RD 21068</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b></p>		<p><b>24B. DATE</b> <b>1/17/72</b></p>		<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Redeemer Cem.</b></p>	
<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Md.</b></p>		<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 19 1972</b></p>			
<p><b>25B. NAME OF REGISTRAR</b> <b>Robert J. ...</b></p>		<p><b>25C. FUNERAL DIRECTOR</b> <b>Schimunek Funeral Home, Inc.</b> <b>13301 Breems Lane</b></p>			

10

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

1-1-1

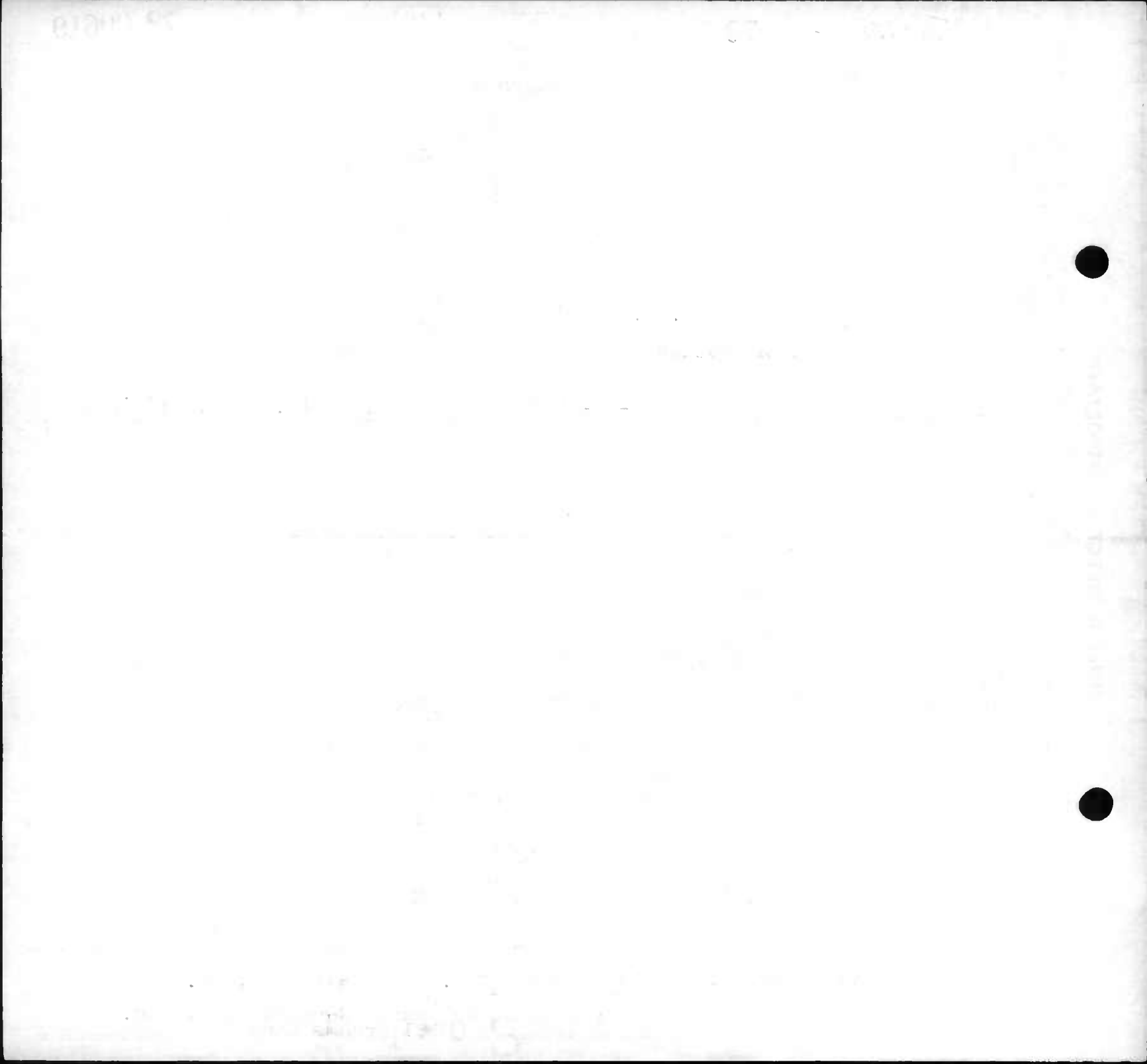
1-1-1

1-1-1

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 00619		72 00619	
BIRTH NO. <b>Z-260</b>		72 00619		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>ZACHAR STEPHEN Lawrence</b>			2. DATE AND HOUR OF DEATH <b>1-13-72 12:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>THE UNION MEMORIAL HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3433 WOODSTOCK AVENUE 21206</b>		
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>04-14-92</b>	9. AGE (In years last birthday) <b>79</b>	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>H. W. Dowling</b>		11. BIRTHPLACE (State or foreign country) <b>WASHINGTON D.C.</b>	
13. FATHER'S NAME <b>John Zachar</b>			14. MOTHER'S MAIDEN NAME <b>Susan Jordan</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>215-22-8335</b>		17. INFORMANT <b>Theresa R. Orbin, dght. 4912 Benton Hgts.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>412.2 I</b> CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>CEREBRAL VASCULAR ACCIDENT</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ASCUD - HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>RESPIRATORY ARREST - CHF - PNEUMONIA - ANEMIA</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-10-1972</b> to <b>1-13-1972</b> that (I) (we) last saw the deceased alive on <b>1-13-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Julio A. Dejo</b>				23B. DATE SIGNED <b>1-13-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>JULIO A. DEJO</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/17/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Md.</b>		24E. STATE (State) <b>Md.</b>		24F. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Julio A. Dejo</b>		25C. ADDRESS <b>3331 Brehms Lane</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span style="font-size: 2em;">S-315</span> <span>72 00620</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>BIRTH NO.</span> <span>72 00620</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>CITY HEALTH DEPARTMENT</span> <span>REG. NO.</span> </div>	
1. NAME OF DECEASED (Type or Print) <b>RUTH STEPHENS</b>			2. DATE AND HOUR OF DEATH <b>1-17-72</b>   <b>8:02 A. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION: <b>35 CHURCH HOME AND HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE: <b>MD</b> B. COUNTY: <b>201</b> C. CITY OR TOWN: <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER: <b>2027 E BALTIMORE STREET</b>		
5. SEX: <b>F</b>	6. RACE: <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH: <b>2.15.17</b>	9. AGE (In years last birthday): <b>54</b>	If Under 1 Yr. Months: Days:    If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <b>WAITRESS</b>		10B. KIND OF BUSINESS OR INDUSTRY: <b>WHITE COFFEE POT</b>		11. BIRTHPLACE (State or foreign country): <b>NORTH CAROLINA</b>	
12. CITIZEN OF WHAT COUNTRY: <b>U.S.A.</b>		13. FATHER'S NAME: <b>WILLIAM EDWARDS</b>		14. MOTHER'S MAIDEN NAME: <b>DAISY TAYLOR</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service): <b>NO</b>		16. SOCIAL SECURITY NO.: <b>266 307108</b>		17. INFORMANT: <b>Prabir K. Bose</b> ADDRESS: <b>Church Home &amp; Hospital</b>	
18. <b>347.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BRAIN DAMAGE</b> (B) <b>EPISTAXIS and Aspiration</b> DUE TO, OR AS A CONSEQUENCE OF: <b>with Respiratory failure</b> (C) _____		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>CIRRHOSIS</b>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION: <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No): <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.): 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location):			
21D. TIME OF INJURY (APPROX.): (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED: While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-15-1972</b> to <b>1-17-1972</b> . that (I) (we) last saw the deceased alive on <b>1-17-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE: <b>Prabir K. Bose M.D.</b>				23B. DATE SIGNED: <b>1-17-72</b>	
23C. PHYSICIAN'S NAME (Type): <b>PRABIR K. BOSE M.D.</b>				23D. ADDRESS: <b>CHURCH HOME AND HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify): <b>BURIAL</b>		24B. DATE: <b>1/21/72</b>		24C. NAME OF CEMETERY or CREMATORY: <b>PINEWOOD FOREST CEM.</b>	
24D. LOCATION: <b>GREENVILLE N.C.</b>		24E. DATE REC'D BY HEALTH DEPT.: <b>JAN 19 1972</b>			
25A. NAME OF REGISTRAR: <b>Dr. E. J. ...</b>		25B. NAME OF REGISTRAR: <b>Dr. E. J. ...</b>		25C. FUNERAL DIRECTOR: <b>Dr. E. J. ...</b>	
25D. ADDRESS: <b>1800 E. LOMBARD ST.</b>					

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

1950

P-400

72 00621

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00621

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ROBERT POOLE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>34 Bon Secours Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 16 1972 11:20 a.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1902</b>	
9. DATE OF BIRTH <b>Feb. 11, 1907</b>		10. AGE (In years last birthday) <b>64</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Loudoun Co., Va.</b>		12. CITIZEN OF <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>579-09-9846</b>	
13. FATHER'S NAME <b>James E. Poole</b>		15. MOTHER'S MAIDEN NAME <b>Margaret V. LeFoyre</b>	
18. INFORMANT <b>Nellie M. Poole</b>		1408 W. Pratt St. Baltimore, Md.	

19. <b>450X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Massive pulmonary embolism</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Notural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>R. S. Fisher</b> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-17-72</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/19/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Union</b>	
24D. LOCATION (City, town, or county) <b>Leesburg</b>		24E. ADDRESS <b>Va</b>		24F. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>	
24G. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		24H. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b>		24I. ADDRESS <b>6500 York Rd Balto.Md. 21212</b>	

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST

15000 ST



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00622</b>	
7-453 72 00622		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Estelle Mrs. Sadie E. Zolontz</b>	
2. DATE AND HOUR OF DEATH <b>1/11/72 - 12:50 P.M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Bon Secours Hospital 34</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2610</b>	
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. DATE OF BIRTH <b>4/6/07</b> 9. AGE (In years last birthday) <b>64</b>		E. STREET AND NUMBER <b>128 S. East Ave. 21224</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William F. Eberwein</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Fossler</b>	
15. Was Deceased Ever in U. S. Armed Forces? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Edward Zolontz, husband, above</b>		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Breast Carcinoma with metastasis</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1/4 '72 - 1/11 '72</b>	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 4</b> 19 <b>72</b> to <b>Jan 11</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Jan. 11</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Masahiro Sugawara M.D.</b>		23B. DATE SIGNED <b>Jan. 11 '72</b>	
23C. PHYSICIAN'S NAME (Type) <b>MASAHIRO SUGAWARA M.D.</b>		23D. ADDRESS <b>B.S.H. Balto. Md. 21223</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/15/72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert C. ...</b>	
25C. FUNERAL DIRECTOR <b>Schimmuck Funeral Home</b>		ADDRESS <b>3331 Brehms Lane</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 00623</u>	
E-663 72 00623		CERTIFICATE OF DEATH	
BIRTH NO. <u>72 00623</u>		1. NAME OF DECEASED (Type or Print) <u>EAR HART, NORMAN DEWITT</u>	
2. DATE AND HOUR OF DEATH <u>1-12-72</u> <u>1206</u> <u>PM</u>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <u>North Charles General Hospital</u> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <u>49</u>	
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>21206</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>5400 Bucknell Road</u> <u>2641</u>		5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>2-26-12</u> 9. AGE (In years last birthday) <u>59</u> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Insurance Agent</u> 10B. KIND OF BUSINESS OR INDUSTRY <u>Ins. Co. southern Western</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Norman H. Earhart</u> 14. MOTHER'S MAIDEN NAME <u>Carrie Wareheim</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>213-05-1577</u> 17. INFORMANT <u>Wm. Richardson</u> ADDRESS <u>21234</u>	
18. <u>59001</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>pulmonary embolism</u> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION <u>11-7-72</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>diffuse lobes</u>		20A. AUTOPSY? (Yes or No) <u>No</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12-27</u> 19 <u>71</u> to <u>1-12</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1-12</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>George H. Bekir</u> DEGREE		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <u>GEORGE HEBEKIR</u> DEGREE		23D. ADDRESS <u>7151 Holborn Ave. Baltimore, Md. 21222</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/15/72</u>	
24C. NAME OF CEMETERY OR CREMATORY <u>Baltimore Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 19 1972</u>		25B. NAME OF REGISTRAR <u>John E. Kelly</u>	
25C. FUNERAL DIRECTOR <u>Schimmek Funeral Home, Inc.</u>		ADDRESS <u>3331 Brehms Lane</u>	

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

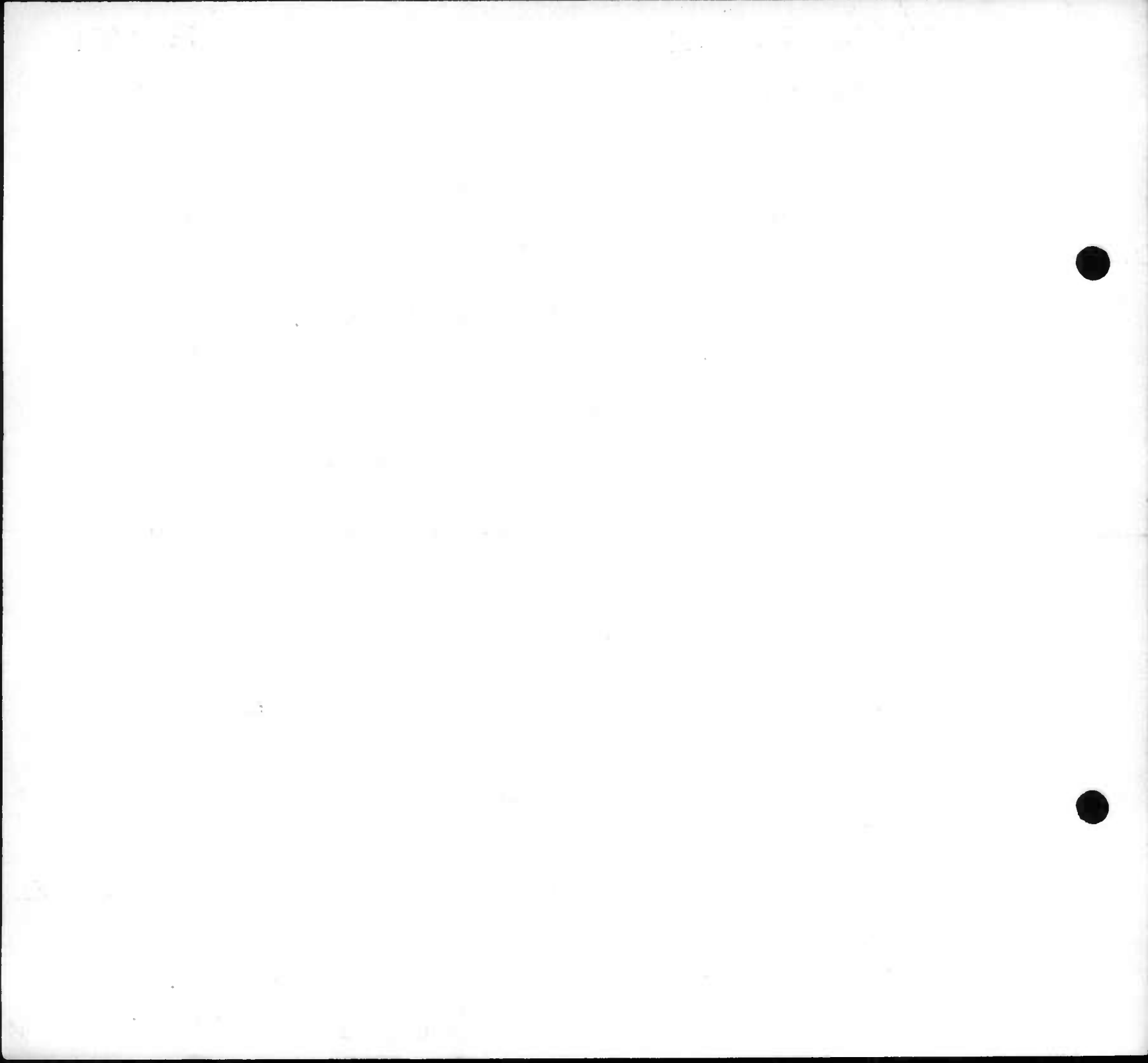
1000

1000

1000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00624</b>	
<b>CERTIFICATE OF DEATH</b>			
BIRTH NO. <b>M-506 72 00624</b>			
1. NAME OF DECEASED (Type or Print) <b>MANN, FLORENCE Catherine</b>		2. DATE AND HOUR OF DEATH <b>JAN. 12, 1972 10<sup>05</sup> A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>91 Montebello State Hospital</b>		4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>833</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3421 PARKLAWN Ave 21213</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-12-00</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>C-P Telephone</b>	9. AGE (In years last birthday) <b>72</b>
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Benjamin T. Mann</b>		14. MOTHER'S MAIDEN NAME <b>Victoria Phillips</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. <b>212 051658</b>	
17. INFORMANT <b>Patient's chart</b>		ADDRESS	
18. <b>428X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Cardio-respiratory Failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>(A) IMMEDIATE CAUSE</b> <b>(B) Myocardial Damage</b> <b>(C)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 minutes</b> <b>Many years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Thoracic Meningioma with Paraplegia</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>10-13-1971</b> to <b>1-12-1972</b> that (I) (we) last saw the deceased alive on <b>1-12-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Hanson S. H. Chen</b>		23B. DATE SIGNED <b>January 12, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>HANSON S. H. CHEN, M.D.</b>		23D. ADDRESS <b>Montebello State Hospital, 2201 Argonne Drive, Baltimore, Md. 21218</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/15/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>John E. ...</b>	
25C. FUNERAL DIRECTOR <b>Schimunek Funeral Home, Inc.</b>		ADDRESS <b>3831 Brehms Lane</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00625

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Wilmer Bond Heckrotte</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 15 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 2 N. Gay Street- Room 217</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 15 72 12:10 P.M.</b>	
6. SEX <b>male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Catonsville</b>	
9. DATE OF BIRTH <b>10-4-1906</b>		10. AGE (In years last birthday) <b>65</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Harry W. Heckrotte</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Emma Kries</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>213-20-3958</b>		18. INFORMANT ADDRESS <b>Little Sisters of the Poor, 601 Maiden Choice Lane</b>	
19. <b>577.8</b> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Fatty metamorphosis of liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b>		DATE SIGNED <b>1/16/72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-19-1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert C. Fisher, Md.</b>	
25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>		ADDRESS	

75 0685

75 0685

11-10-1975

7

Colonel

11-10-1975

11-10-1975

11-10-1975

11-10-1975

11-10-1975

11-10-1975

11-10-1975

11-10-1975

11-10-1975



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">6-536</span>		72 00626		DEPARTMENT		REG. NO. <span style="float: right;">72 00626</span>	
1. NAME OF DECEASED (Type or Print) <b>GUNTHER, ALLENA.</b>				2. DATE AND HOUR OF DEATH <b>1/13/72 10:25 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 Union Memorial Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1307</b>			
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3838 ROLAND AV.</b>			
5. SEX <b>FEM.</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/25/88</b>	9. AGE (In years last birthday) <b>83</b>	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Housewife</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas A. Outland</b>				14. MOTHER'S MAIDEN NAME <b>ISABEL COPELAND</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. 193D <b>216 10 6</b>		17. INFORMANT ADDRESS <b>Mrs. M. Rodemeyer Lutherville, Md.</b>			
18. <b>482.9 1-25-0.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>SEPTICEMIA</b> <b>PNEUMONIA</b> <b>CONGESTIVE HEART FAILURE, DIABETES</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/13/72</b> 19 to <b>1/13/72</b> 19 that (I) (we) last saw the deceased alive on <b>1/13/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>R. del Busto MD</b>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>R. del Busto MD</b>	
23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1/17/72</b>				24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>				25B. NAME OF REGISTRAR <b>Calvin E. J. ...</b>		25C. FUNERAL DIRECTOR ADDRESS <b>MITCHELL-WIEDEFELD 6500 York Rd.</b>	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00627

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>ANGELA SWANN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 8, 1972</b>		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 3912 Duval</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 8, 1972</b>		Hour <b>1:29 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1509</b>					
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>Sept 5 - 1961</b>		10. AGE (In years last birthday) <b>10</b>	11. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Baltimore</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		E. STREET AND NUMBER <b>3912 Duval Ave</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Student</b>		14B. KIND OF BUSINESS OR INDUSTRY		15. MOTHER'S MAIDEN NAME <b>Selma P.</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		18. INFORMANT <b>Selma Swann</b> ADDRESS: <b>3912 Duval Ave</b>	
19. <b>780.2</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Terminal aspiration presumably during seizure</b> (A) IMMEDIATE CAUSE <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  (B) <b>DUE TO, OR AS A CONSEQUENCE OF:</b>  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type): <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: <b>January 9, 1972</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-13-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary Cem</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 19 1972</b>		25B. NAME OF REGISTRAR <b>Robert C. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Rayner Sanders</b> ADDRESS: <b>217 E Preston St</b>	

3-1-1972 - Completion of cause of death on a pending medical examiner death certificate  
C. Springate, M.D.

HRS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-000		72 00628		BALTIMORE CITY HEALTH DEPARTMENT		72 00628	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <i>Shaw, ANNIE Lue</i>				2. DATE AND HOUR OF DEATH <i>Jan 17, 1972</i> 1:10 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1702</i>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>31 Baltimore City Hospitals</i> <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>				C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <i>1123 Tiffany Court, Baltimore 21201</i>							
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>1-20-1909</i>	9. AGE in years (last birthday) <i>62</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House wife</i>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>	
13. FATHER'S NAME <i>Rufus Harrison</i>				14. MOTHER'S MAIDEN NAME <i>Lucy J. Jefferson</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <i>212-14-9358</i>		17. INFORMANT <i>Records: BCH-4940 Eastern Avenue 21224</i>	
18. <i>153.8</i> I CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <i>Acute Renal Failure</i>		<i>7 days</i>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>Metastatic Liver Disease</i>		<i>3 months</i>	
				(C) <i>Adenocarcinoma of Colon</i>		<i>2 years</i>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<i>Metastatic Disease to Peritoneum</i>		<i>6 weeks</i>	
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>YES</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (H) (this hospital) attended the deceased from <i>January 16</i> 19 <i>72</i> to <i>January 17</i> 19 <i>72</i> that (H) (we) last saw the deceased alive on <i>January 17</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>William P. Hunt M.D.</i>				23B. DATE SIGNED <i>January 17, 1972</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <i>William P. Hunt</i>				23D. ADDRESS <i>4940 Eastern Avenue</i> <i>Baltimore, Maryland 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/22/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Ch. B. Cemetery</i>		24D. LOCATION (City, town, or county) (State) <i>MD</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1972</i>		25B. NAME OF REGISTRAR <i>John E. Hunt</i>		25C. FUNERAL DIRECTOR <i>William P. Hunt</i>		ADDRESS <i>4940 Eastern Avenue</i>	

~~CONFIDENTIAL - SECURITY INFORMATION~~

SECRET

...

SECRET

SECRET

SECRET

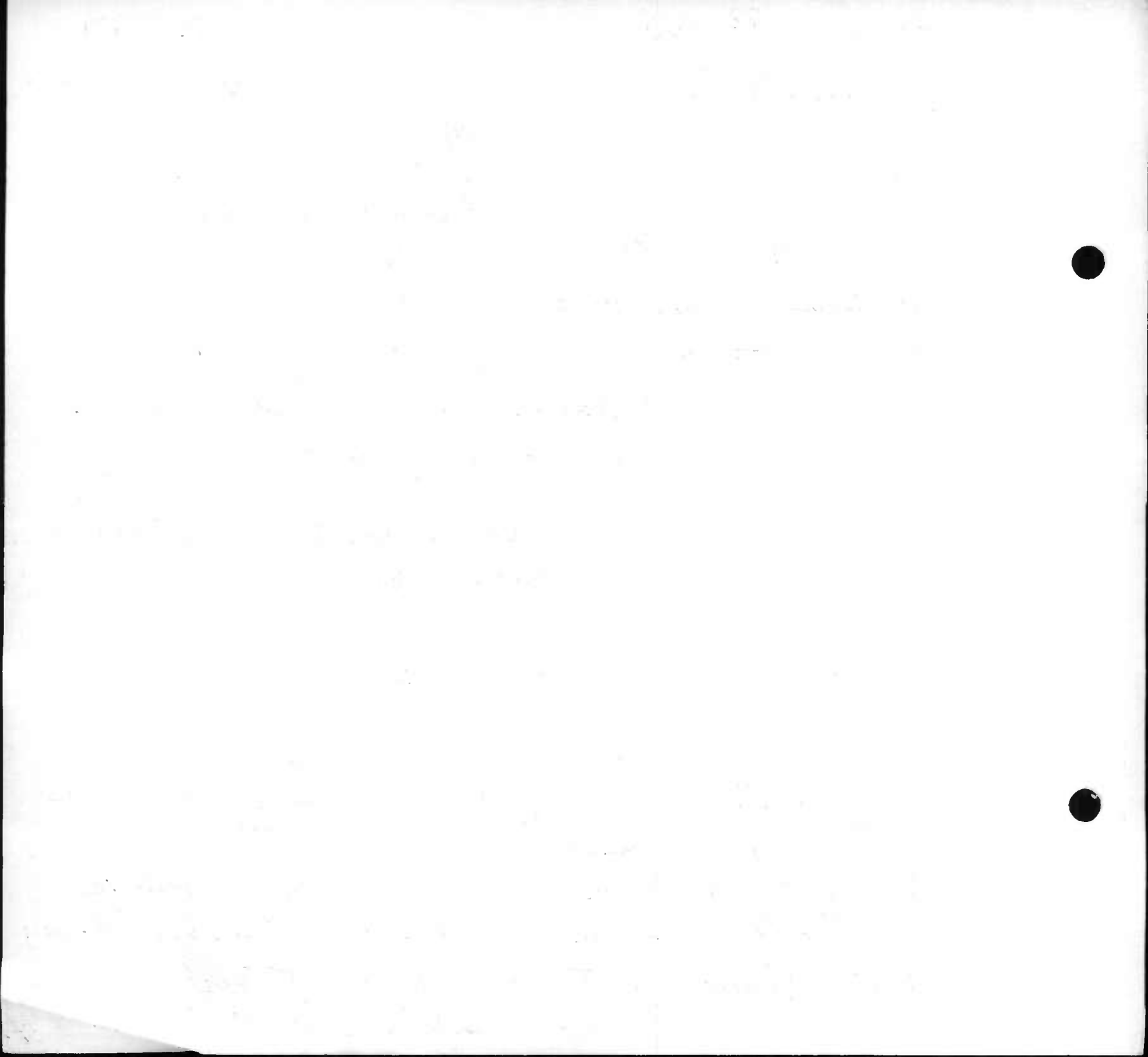
SECRET

SECRET

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

A-620		72 00629		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00629	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <i>Robert Cecil Ayers</i>				2. DATE AND HOUR OF DEATH <i>1-13-72 10:10 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Md. Gen. Hosp.</i>				A. STATE <i>Md.</i>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				B. COUNTY <i>1</i>			
C. CITY OR TOWN <i>Baltimore</i>				D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
E. STREET AND NUMBER <i>Parkwood Ave 2805</i>							
5. SEX <i>M</i>	6. RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>3-15-17</i>		9. AGE (In years last birthday) <i>54</i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Welder</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Sparrow Point</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Thomas R. Ayers</i>				14. MOTHER'S MAIDEN NAME <i>Matilda Jones</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>?</i>				16. SOCIAL SECURITY NO. <i>215-05-8426</i>		17. INFORMANT <i>Harold Ayers</i>	
18. <i>412.491.250.9</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <i>CHF - Pulm. Edema</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Chronic Renal Failure</i>		(B) DUE TO, OR AS A CONSEQUENCE OF: <i>&gt; 2 years</i>	
				(C) <i>ASCVD - DMelitus</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>—</i>		20A. AUTOPSY? (Yes or No) <i>No</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <i>—</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) <i>—</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>—</i>			
22. I certify that (I) (this hospital) attended the deceased from <i>1-11-1972</i> to <i>1-13-1972</i> that (I) (we) last saw the deceased alive on <i>1-13-1972</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Arnold G. Alexander MD</i>				23B. DATE SIGNED <i>1-13-72</i>			
23C. PHYSICIAN'S NAME (Type) <i>Arnold G. Alexander MD</i>				23D. ADDRESS <i>827 Linden Ave. Balt. Md. 21201</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/17/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Arbutus Mem. Sk. Baltimore Md.</i>		24D. LOCATION (City, town, or county) (State) <i>Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 19 1972</i>		25B. NAME OF REGISTRAR <i>Baltimore</i>		25C. FUNERAL DIRECTOR <i>W. Phillips</i>			
				ADDRESS <i>1727 N. Mount St.</i>			





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00630

BIRTH NO.

1. NAME OF DECEASED (Type or Print) **Wardell Jeffers**

2. DATE OF DEATH Known ☒ Estimated ☐ Month **1** Day **13** Year **72** Hour **10:40** M. **P.**

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
**Provident Hospital**

3. DATE PRONOUNCED DEAD Month **1** Day **13** Year **72** Hour **10:40** M. **P.**

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE **Md.** B. COUNTY **1304**

6. SEX **male** 7. RACE **Negro** 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ C. CITY OR TOWN **Balto.** D. INSIDE CITY LIMITS? YES ☐ NO ☐

9. DATE OF BIRTH **May 21, 1925** 10. AGE (In years last birthday) **46** 11. BIRTHPLACE (State or foreign country) **North Carolina** 12. CITIZEN OF WHAT COUNTRY? **USA** 13. FATHER'S NAME **John Jeffers**

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Retired** 14B. KIND OF BUSINESS OR INDUSTRY **Hattie Bailey** 15. MOTHER'S MAIDEN NAME **Hattie Bailey**

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) **Yes** 17. SOCIAL SECURITY NO. **241-20-0148** 18. INFORMANT **Mrs. Joyce Jeffers** ADDRESS **1625 Gwynns Falls Parkway**

19. **412.4** CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  
**Arteriosclerotic cardiovascular disease**

ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  
(B) DUE TO, OR AS A CONSEQUENCE OF:  
(C) DUE TO, OR AS A CONSEQUENCE OF:

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION **2** 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED **yes** 21. AUTOPSY? (Yes or No) **yes**

22A. EXTERNAL CAUSE WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.) 22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ 22F. HOW DID INJURY OCCUR?

23. I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: **Natural causes** ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE **Peter Lipkovic, M.D.** CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☒ ASSOCIATE MEDICAL EXAMINER ☐ DATE SIGNED **1/14/72**

24A. BURIAL CREMATION, REMOVAL (Specify) **Burial** 24B. DATE **1-18-72** 24C. NAME of CEMETERY or CREMATORY **Baltimore National** 24D. LOCATION (City, town, or county) (State) **Baltimore, Maryland 2**

25A. DATE REC'D BY HEALTH DEPT. **JAN 19 1972** 25B. NAME OF REGISTRAR **Robert E. Fisher, M.D.** 25C. FUNERAL DIRECTOR **Arlington S. Phillips** ADDRESS **1727 N. Monroe Street**

ST. JOHN

ST. JOHN

ST. JOHN

ST. JOHN

ST. JOHN

ST. JOHN

ST. JOHN

ST. JOHN

ST. JOHN

ST. JOHN

ST. JOHN

ST. JOHN

ST. JOHN

ST. JOHN

ST. JOHN

ST. JOHN

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00631</u>
BIRTH NO. <u>L-125</u>		72 00631		
1. NAME OF DECEASED (Type or Print) <u>Lipscomb, Luettal.</u>		2. DATE AND HOUR OF DEATH <u>January 16, 1972</u> <u>9:20 P.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Good Samaritan Hospital</u> <u>Baltimore, Md.</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2802</u>		
5. SEX <u>F</u>		6. RACE <u>B</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>07-04-38</u>		9. AGE (In years last birthday) <u>33</u>		10. UNDER 1 Yr. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Teacher</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>James R. Lipscomb</u>		
14. MOTHER'S MAIDEN NAME <u>Fannie L. Tipton</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		
16. SOCIAL SECURITY NO. <u>235-60-4606</u>		17. INFORMANT <u>Mr. &amp; Mrs. James R. Lipscomb</u>		
18. CAUSE OF DEATH <u>CARDIOVASCULAR ARREST 2° to</u> <u>(A) IMMEDIATE CAUSE ASPIRATION</u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) ? SEPSIS WITH MENINGITIS</u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) SYSTEMIC LUPUS ERYTHEMATOSUS + NEPHRITIS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>December 29, 1971</u> to <u>January 16, 1972</u> that (I) (we) last saw the deceased alive on <u>January 16, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Lawrence E. Shulman</u>		23B. DATE SIGNED <u>Jan 16, 1972</u>		
23C. PHYSICIAN'S NAME (Type) <u>Lawrence E. Shulman M.D.</u>		23D. ADDRESS <u>The Johns Hopkins Hospital, Balt., Md.</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-20-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Maryland National Memorial Park</u>
24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>		25A. FUNERAL DIRECTOR <u>Arundel S. Phillips</u>		
25B. NAME OF REGISTRAR <u>Arundel S. Phillips</u>		25C. ADDRESS <u>1727 N. Monroe Street</u>		

1-24-1972 - Correction form from Funeral Director - Arlington S. Phillips  
per Gwendolyn Williams

HRS

C-652

72 00632 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00632

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Russell Carrington Jr.

2. DATE OF DEATH Known ☒ Estimated ☐ Month 1 Day 17 Year 72 Hour 8:40 P.M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Lutheran Hospital

3. DATE PRONOUNCED DEAD Month 1 Day 17 Year 72 Hour 8:40 P.M.

5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)

A. STATE Maryland B. COUNTY 2775

6. SEX

Male

7. RACE

Negro

8. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☐ SEPARATED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

May 11, 1932

10. AGE (In years last birthday)

39

If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

107-C Cross Keys Rd.

11. BIRTHPLACE (State or foreign country)

New York

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Russell H. Carrington, Sr.

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Dentist

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Geneva Preston

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

Yes

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

Barbara A. Carrington 8120 Arrowhead Road

19. E970X1

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Gunshot wound of abdomen  
DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C)

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

Yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
Office bldg.

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

Garwyn Med. Center Gwynns Falls &amp; Garrison Blvd.

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

1 17 72 8:10A.

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

Shot by police during crossfire 1538

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE OF EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-18-72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-22-72

24C. NAME OF CEMETERY or CREMATORY

Arbutus Mem. Park 1

24D. LOCATION (City, town, or county) (State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 19 1972

25B. NAME OF REGISTRAR

James E. Taylor, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

Arlington S. Phillips 1727 N. Monroe Street

25 10035

25 10035

25 10035

25 10035

25 10035

25 10035

25 10035

25 10035

25 10035

25 10035

25 10035

25 10035

25 10035

25 10035

25 10035

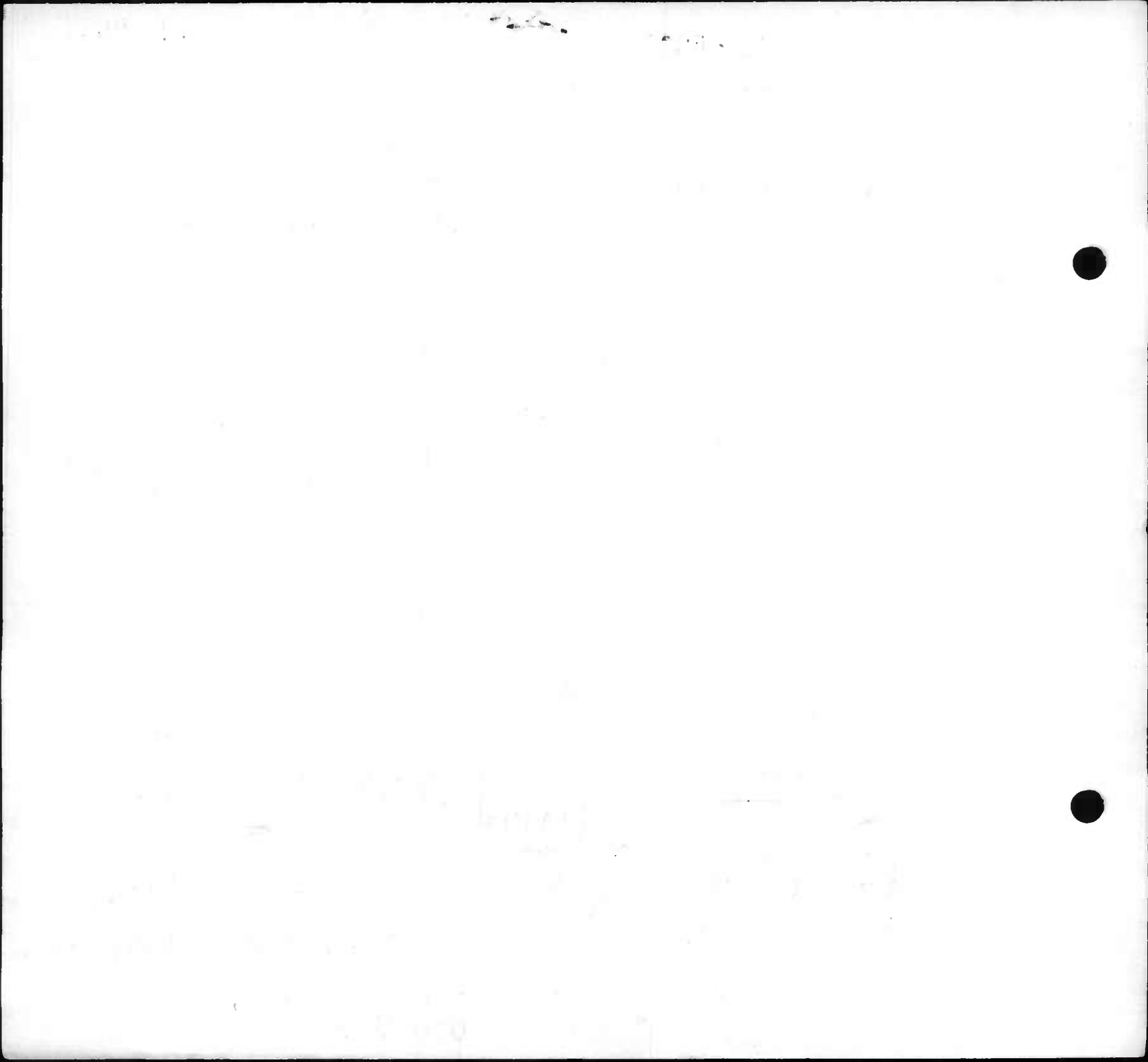
25 10035

25 10035

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 00633		REG. NO. 72 00633	
BIRTH NO. <u>W-420</u>		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>JOHN WILLIS</u>		2. DATE AND HOUR OF DEATH <u>1/19/72 1:5 A</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Maryland Ben Hosp</u>		A. STATE <u>Balto</u>		B. COUNTY <u>1402</u>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <u>Balto</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<u>48</u>		E. STREET AND NUMBER <u>1701 Madison Ave</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>10/13/97</u>	9. AGE (In years last birthday) <u>74</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>	
13. FATHER'S NAME <u>Fred Willis</u>		14. MOTHER'S MAIDEN NAME <u>Susie</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>217-05-5575</u>		17. INFORMANT <u>Mrs Louise Thomas, Same</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>2° burns about body</u>		CAUSE OF DEATH <u>2° burns about body</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3d</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>ASCVD</u>			
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>None</u>		20A. AUTOPSY? (Yes or No) <u>yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>1701 Madison 1402</u>	
21D. TIME OF INJURY (APPROX.) <u>1/16/72 1 PM</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Scalded in bathtub</u>	
22. I certify that (1) <del>this hospital</del> attended the deceased from <u>1/16/72</u> to <u>1/19/72</u> and that (1) <del>we</del> last saw the deceased alive on <u>1/19/72</u> and that in (my) <del>and</del> opinion death occurred on the date and hour and from the causes stated above. (1) <del>we</del> (did) <del>not</del> view the body after death.					
23A. SIGNATURE <u>Karl G. Mealy Jr</u>		23B. DATE SIGNED <u>1/19/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Karl G. Mealy Jr</u>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/22/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT Auburn Cemetery</u>	
24D. LOCATION <u>Baltimore, Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>	
25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u>		25D. ADDRESS <u>1206 W North Ave</u>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-540		72 00634		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00634	
1. NAME OF DECEASED (Type or Print) <u>Fennell James</u>				2. DATE AND HOUR OF DEATH <u>1-17-72</u> <u>10:45</u> AM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Mt. Sinai Nursing Home</u> <u>4413 Park Heights Ave. 21215</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1607</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>1024 Rosedale St. 21216</u>			
5. SEX <u>M.</u>	6. RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-19-03</u>	9. AGE (in years last birthday) <u>69</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		
13. FATHER'S NAME <u>Unknown</u>			14. MOTHER'S MAIDEN NAME <u>Unknown</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>218-22-8484</u>		17. INFORMANT ADDRESS <u>Mr Russell Croamartie, same</u>		
18. <u>404X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH <u>Woman</u> (A) IMMEDIATE CAUSE <u>Hypertensive Arteriosclerosis</u> <u>Cardio Vascular Renal Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>None</u> (C) <u>None</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>None</u> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>None</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u> <u>1 year</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>January 11 1972</u> to <u>January 17 1972</u> that (I) (we) last saw the deceased alive on <u>January 17 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Manuel Levin</u>				23B. DATE SIGNED <u>1/17/72</u>		23C. PHYSICIAN'S NAME (Type) <u>MANUEL LEVIN</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>				24B. DATE <u>1/19/72</u>		24C. NAME of CEMETERY or CREMATORY <u>MT Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>A A County Md</u>				25A. DATE REG. BY HEALTH DEPT. <u>JAN 20 1972</u>			
25B. NAME OF REGISTRAR <u>Robert S. Vebey</u>				25C. FUNERAL DIRECTOR <u>Adolphus Halstead</u>			
25D. ADDRESS <u>1206 W North ave</u>							

Washburn

*[Faint handwritten notes at the bottom of the page, likely bleed-through from the reverse side.]*

—

— 八 —

Forward 915 579 11 55 7 Forward 915 579 11 55

1111

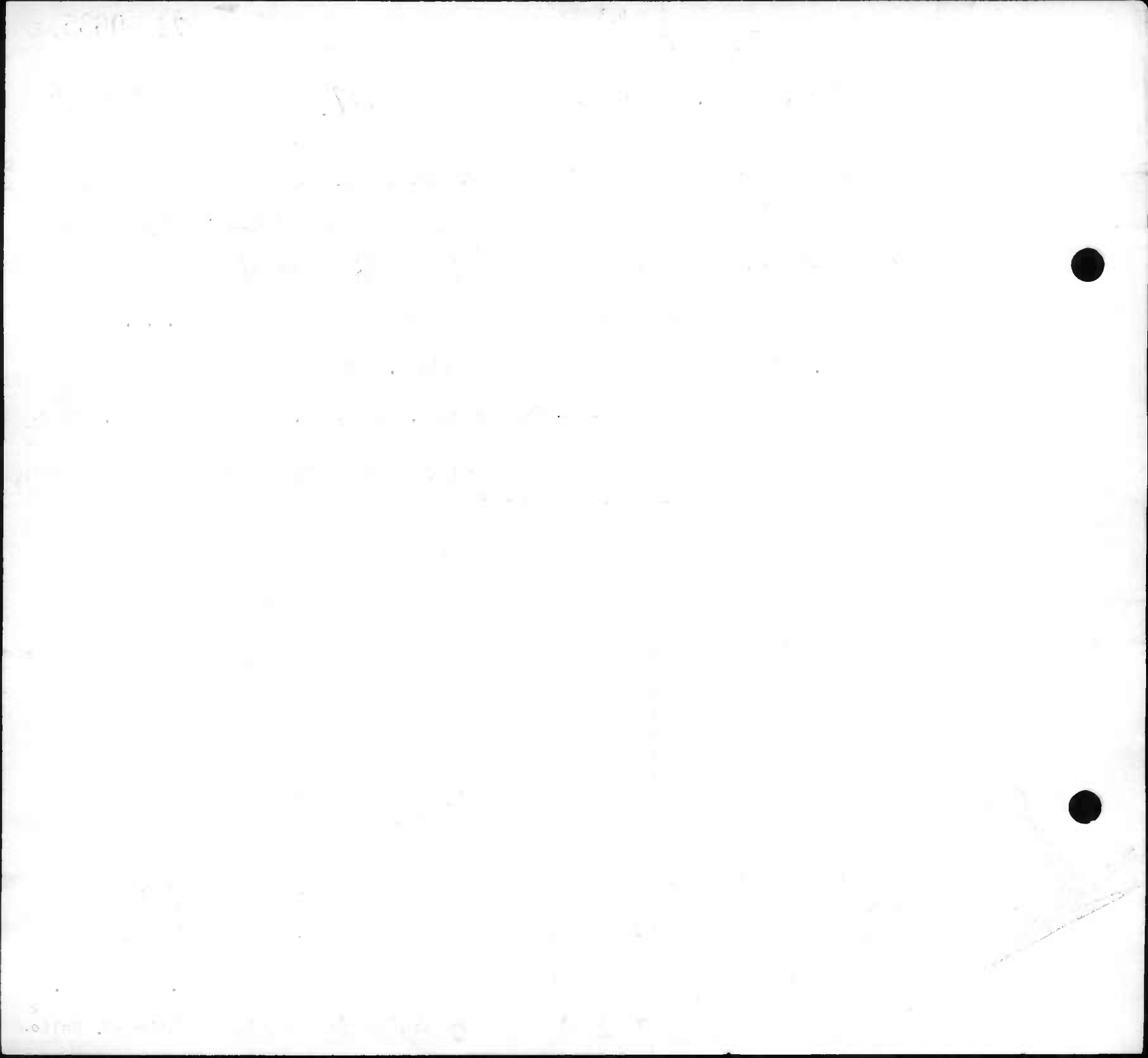
1/20/1914

Alvarez is now in a better position to make a decision.

FUNERAL DIRECTOR: IMPORTANT

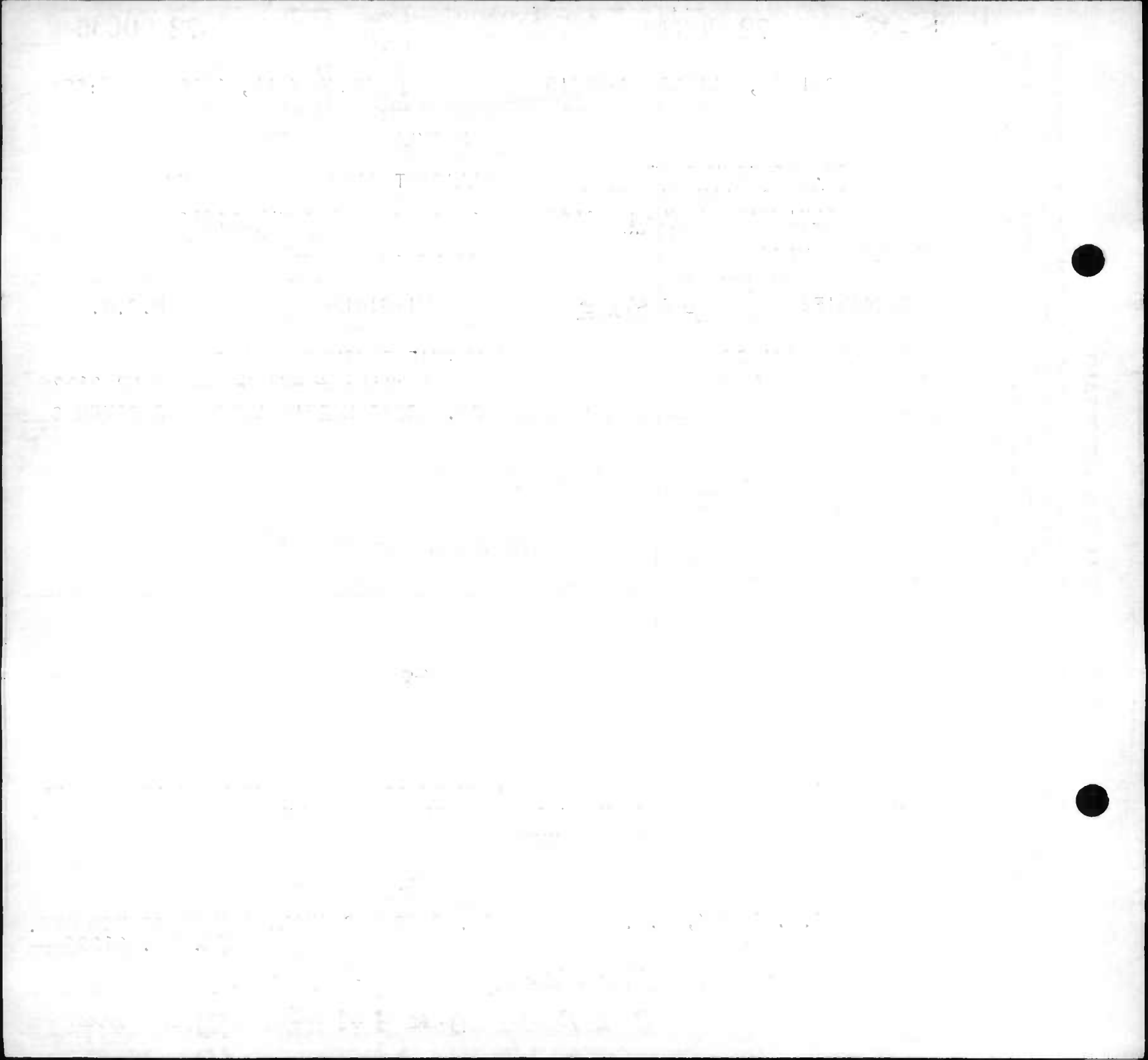
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-650		BALTIMORE CITY HEALTH DEPARTMENT		72 00635	
72 00635		CERTIFICATE OF DEATH		REG. NO. 72 00635	
1. NAME OF DECEASED (Type or Print) <b>BROWN, ALICE</b>		2. DATE AND HOUR OF DEATH <b>1/17/72 1:25 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTO.</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSP. OF BALTO.</b>		C. CITY OR TOWN <b>PERRY HALL</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>FEMALE</b>		6. RACE <b>CAUCASIAN</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>8/12/22</b>		9. AGE (In years last birthday) <b>49</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>James C. Gaitley</b>	
14. MOTHER'S MAIDEN NAME <b>Marie A. Brandt</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-11-9535</b>	
17. INFORMANT <b>Harry T. Brown, Jr.</b>		ADDRESS <b>8814 Deerborn Dr. Balto.</b>		21236	
18. <b>174X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>CA OF BREAST</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 MONTHS</b>			
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CA OF BREAST</b>			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/16/72</b> to <b>1/17/72</b> and that (I) (we) lost saw the deceased alive on <b>1/16/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>[Signature]</b>		23B. DATE SIGNED <b>1/17/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>DAVID GLASER, M.D.</b>		23D. ADDRESS <b>SINAI HOSP. OF BALTO.</b>			
24A. BURIAL REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Gardens Of Faith Cemetery</b>	
24D. LOCATION <b>Overlea Balto. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1972</b>		25B. NAME OF REGISTRAR <b>[Signature]</b>	
25C. FUNERAL DIRECTOR <b>Isaiah Funeral Home</b>		ADDRESS <b>7401 Belair Rd. Balto.</b>		21236	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00636</b>	
S-160 72 00636		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>SEIBER, ALIENE GEORGIA</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 14, 1972 8:30A</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>ST. AGNES HOSPITAL</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <b>CATON &amp; WICKENS AVENUE BALTIMORE MARYLAND 21229</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>HOWARD</b> C. CITY OR TOWN <b>ELLICOTT CITY</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3973 WEAVERS COURT 21043</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>09 25 19</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	9. AGE (In years last birthday) <b>52</b>
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>CHARLES ROBINSON</b>		14. MOTHER'S MAIDEN NAME <b>MATTIE FREEMAN ROBINSON</b>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-38-6561</b>	
17. INFORMANT <b>WILKENS AVENUE BALTO MD 21229</b>		18. CAUSE OF DEATH <b>ST. AGNES HOSPITAL RECORDS CATON &amp;</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>2</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>hrs.</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Inditely medical examined) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>JANUARY 12</b> 19 <b>72</b> to <b>JANUARY 14</b> 19 <b>72</b> that (X) (we) last saw the deceased alive on <b>JANUARY 14</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (d) (XXX) view the body after death.			
23A. SIGNATURE <b>C. R. Chaney</b>		23B. DATE SIGNED <b>1/14/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>C. R. CHANEY, M.D.</b>		23D. ADDRESS <b>ST. AGNES HOSPITAL, WILKENS &amp; CATON AVE. BALTO MD 21229</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-17-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Crest Lawn</b>		24D. LOCATION <b>Ellicott City Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1972</b>		25B. NAME OF REGISTRAR <b>Robert J. ...</b>	
25C. FUNERAL DIRECTOR <b>Ellicott City, Md.</b>		25D. ADDRESS	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-320		72 00637		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00637	
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) YATES SARAH ELIZABETH				2. DATE AND HOUR OF DEATH 01-17-72 10:10AM M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND B. COUNTY HOWARD C. CITY OR TOWN ELICOTT CITY D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 8482 WEST MAIN ST			
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 10 29 15	9. AGE (In years last birthday) 56	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE		10B. KIND OF BUSINESS OR INDUSTRY at home		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? UNITED STATES	
13. FATHER'S NAME GEORGE YATES 220 18 6461				14. MOTHER'S MAIDEN NAME MARGARET ELLEN MAYFIELD			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT ST AGNES MEDICAL RECORDS BALTO MD WILKENS AND CATON AVE.			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				(A) IMMEDIATE CAUSE Pneumonia, Lt lower lobe DUE TO, OR AS A CONSEQUENCE OF: (B) Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF: (C) Hypertensive ASD			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (X) (this hospital) attended the deceased from JANUARY 8 19 72 to JANUARY 17 19 72 that (X) (we) last saw the deceased alive on JANUARY 17 19 72 and that (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Johnny Soon Lee				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) JOUNG SOON LEE M.D.				23D. ADDRESS CATON & WILKENS AVENUE 21229			
24A. BURIAL CREMATION, REMOVAL (Specify) burial		24B. DATE 1/20/72		24C. NAME OF CEMETERY or CREMATORY St. Johns Cem		24D. LOCATION (City, town, or county) (State) Ellicott City, Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1972		25B. NAME OF REGISTRAR J. E. Lee		25C. FUNERAL DIRECTOR Slack Funeral Home, Ellicott City, Md. 21043			

1003 1003 1003

1003 1003 1003

1003 1003 1003

1003 1003 1003

1003 1003 1003

1003 1003 1003

1003 1003 1003

1003 1003 1003

1003 1003 1003

1003 1003 1003

1003 1003 1003

1003 1003 1003

1003 1003 1003

1003 1003 1003

1003 1003 1003

1003 1003 1003

1003 1003 1003



RGB

VS 150-REV. 7/68

U-600						72 00638						BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH						REG. NO. 72 00638																	
BIRTH NO.																																			
1. NAME OF DECEASED (Type or Print)												2. DATE AND HOUR OF DEATH																							
Bruce Wayne Ware												Jan. 17, 1972 5:25 PM																							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD												4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)																							
FULL NAME OF HOSPITAL OR INSTITUTION US Public Health Service Hospital 3100 Wyman Parkway												A. STATE Md. B. COUNTY Balto. C. CITY OR TOWN Parkville D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 3133 Hiss Avenue																							
5. SEX M			6. RACE Caucasian			7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH 9/21/39			9. AGE (In years last birthday) 32			If Under 1 Yr. Months Days			If Under 24 Hrs. Hours Min.																	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Policeman						10B. KIND OF BUSINESS OR INDUSTRY Balto. Co. P.D.						11. BIRTHPLACE (State or foreign country) Md.						12. CITIZEN OF WHAT COUNTRY? USA																	
13. FATHER'S NAME John Ware												14. MOTHER'S MAIDEN NAME Elizabeth ? Koetting																							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No						16. SOCIAL SECURITY NO. 219-36-1213						17. INFORMANT ADDRESS Records- US PHS Hospital, Balto, Md.																							
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.												(A) IMMEDIATE CAUSE Acute & subacute bilateral bronchopneumonia  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ? 2 wks.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Hodgkin's disease, nodular sclerosis type, with metastases to rt. kidney, rt. adrenal & liver												8 1/2 yrs.																							
19A. DATE OF OPERATION 2						19B. CONDITION FOR WHICH OPERATION WAS PERFORMED						20A. AUTOPSY? (Yes or No) yes						20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes																	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)						21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)						21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)																							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)						21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>						21F. HOW DID INJURY OCCUR?																							
22. I certify that (I) (this hospital) attended the deceased from Jan. 17 19 72 to Jan. 17 19 72 that (I) (we) lost saw the deceased alive on Jan. 17 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.																																			
23A. SIGNATURE Robert L. Wright, MD												23B. DATE SIGNED 1/18/72																							
23C. PHYSICIAN'S NAME (Type) Robert Wright, SA Surg (R)												23D. ADDRESS US PHS Hospital, Balto, Md.																							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial						24B. DATE 1/20/72						24C. NAME of CEMETERY or CREMATORY Parkwood Cemetery						24D. LOCATION (City, town, or county) (State) Parkville Balto. Md.																	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1972						25B. NAME OF REGISTRAR						25C. FUNERAL DIRECTOR						ADDRESS																	
Bassahm Funeral Home 7401 Belair Rd. Balto. 21236																																			

1

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

2000 95

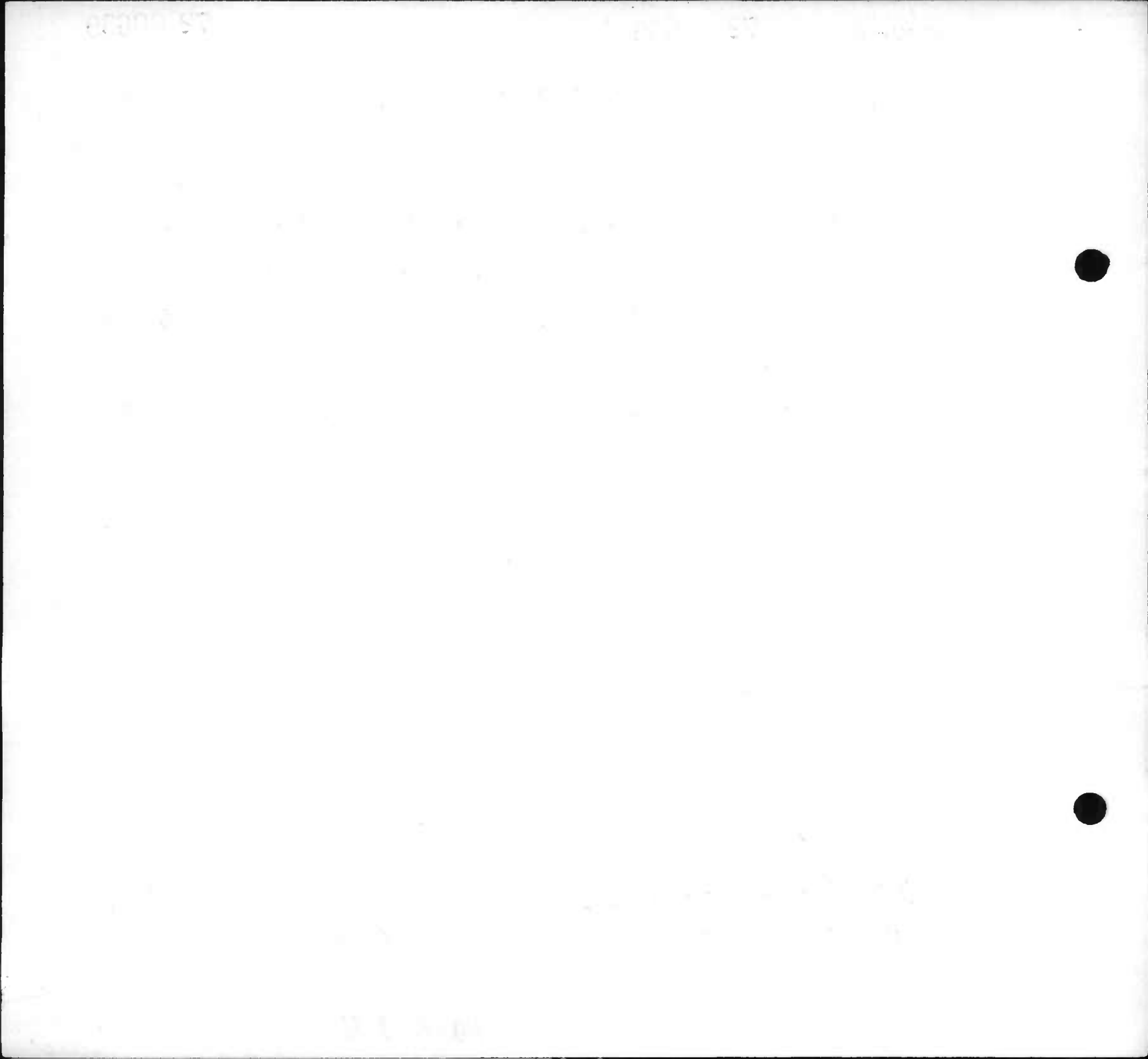
2000 95

2000 95

2000 95

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

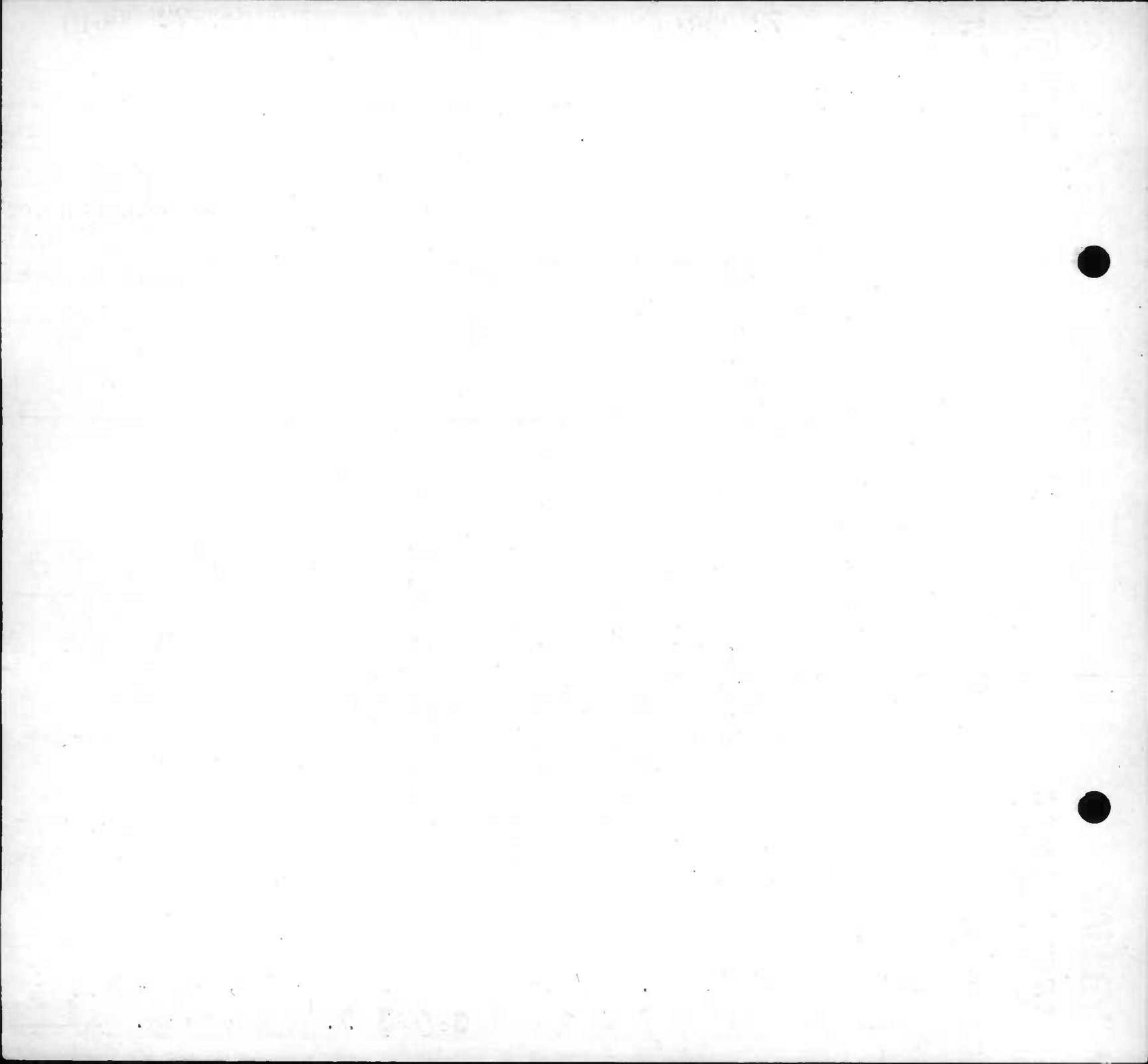
H-426		72 00639		BALTIMORE CITY HEALTH DEPARTMENT		72 00639	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>ALINE A. HEYLIGER</u>				2. DATE AND HOUR OF DEATH <u>1-16-72</u> <u>10:15 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4709 FAIRHAVEN AVE.</u> <u>BALTO. MD. 21226</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>2503</u>			
				C. CITY OR TOWN <u>BALTO.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>4709 FAIRHAVEN AVE</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-2-33</u>	9. AGE (In years last birthday) <u>38</u>	10. Under 1 Yr. Months	11. Under 1 Yr. Days	12. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>OFFICE WORK</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>FT. MEADE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO. MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ENGLE H HEYLIGER</u>				14. MOTHER'S MAIDEN NAME <u>JEZEK</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>216-32-0872</u>		17. INFORMANT <u>Emily Heyliger</u>		ADDRESS <u>SAME</u>	
18. <u>180X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Generalized metastases</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CARCINOMA OF CERVIX</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>7 mos</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>6/7/71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bleeding (CARCINOMA)</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>JUNE 15</u> 19 <u>71</u> to <u>PRESENT</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>JAN. 13</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>1-19-72</u>			
23C. PHYSICIAN'S NAME (Type) <u>DR. J. B. Richards</u> <u>H.G. Summers</u>		23D. ADDRESS <u>1101 Oakwood Ave.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>	24B. DATE <u>1-20-72</u>	24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		24D. LOCATION (City, town, or county) (State) <u>Ritchie Hwy. BALTO. MD.</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. [Signature]</u>		25C. FUNERAL DIRECTOR <u>HAHN FUNERAL Home</u>		ADDRESS <u>4200 Pennsylvania</u> <u>21226</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-206 72 00640		BALTIMORE CITY HEALTH DEPARTMENT		72 00640	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>Roche Anna H.</b>			2. DATE AND HOUR OF DEATH <b>Jan. 15<sup>th</sup>, 1972 6.00 P.M. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <b>South Baltimore Gen. Hospital</b> <b>3001 S. Hanover St., Baltimore, Md 21230.</b>			A. STATE <b>Maryland</b> B. COUNTY <b>AA</b> C. CITY OR TOWN <b>city Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5428, Waseana Aven, Baltimore, Md 21225.</b>		
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-28-15</b>	9. AGE (In years lost birthday) <b>56</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
13. FATHER'S NAME <b>William Gerstmyer (Dec.)</b>			14. MOTHER'S MAIDEN NAME <b>Elizabeth (Dec.)</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-05-1223</b>		17. INFORMANT <b>Augustus Roche, (Husband)</b>	
18. <b>412.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiogenic Shock</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Myocardial Infarction</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>March 1971.</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (H) (this hospital) attended the deceased from <b>1-12-1972</b> to <b>1-15-1972</b> , that (I) (we) last saw the deceased alive on <b>1-15-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Ahmad M.D.</b>				23B. DATE SIGNED <b>1-15-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. AHMAD</b>				23D. ADDRESS <b>3001 S. Hanover St., Baltimore, Md 21230.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/17/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>St. John's Lutheran Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Parkville, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1972</b>			
25B. NAME OF REGISTRAR <b>John J. ...</b>		25C. FUNERAL DIRECTOR <b>McCullough</b>			
ADDRESS <b>237 Patapsco Ave. 21225</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

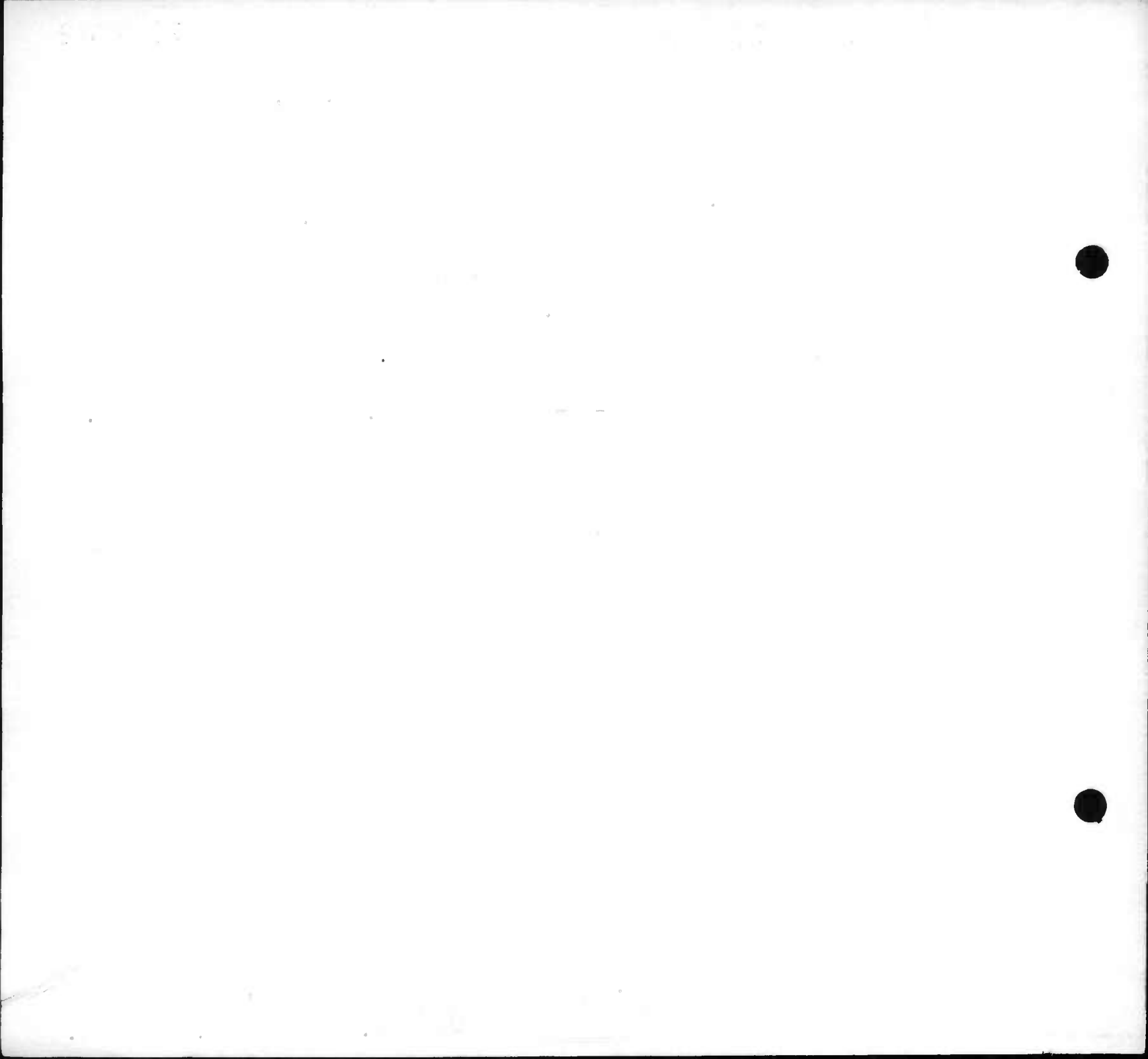
<div style="display: flex; justify-content: space-between;"> <span><b>S-530</b></span> <span><b>72 00641</b></span> </div>		<div style="display: flex; justify-content: space-between;"> <span><b>72 00641</b></span> <span><b>CERTIFICATE OF DEATH</b></span> </div>		<b>REG. NO.</b> _____	
<b>BIRTH NO.</b> _____					
<b>1. NAME OF DECEASED</b> (Type or Print) <b>EMMA L. SMITH</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>January 17, 1972</b> <span style="float: right;"><b>8:30 P. M.</b></span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1114 Ramblewood Road</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>Maryland</b> <b>B. COUNTY</b> <b>27 48</b> <b>C. CITY OR TOWN</b> <b>Baltimore</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>1114 Ramblewood Road</b>		
<b>5. SEX</b> <b>female</b>	<b>6. RACE</b> <b>caucasian</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>6-30-1880</b>	<b>9. AGE</b> (In years last birthday) <b>91</b>	<b>If Under 1 Yr.</b> Months: _____ Days: _____ <b>If Under 24 Hrs.</b> Hours: _____ Min: _____
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>		
<b>10B. KIND OF BUSINESS OR INDUSTRY</b>			<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>		
<b>13. FATHER'S NAME</b> <b>Roland G. Stoddard</b>			<b>14. MOTHER'S MAIDEN NAME</b> <b>Hannah Gage</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>			<b>16. SOCIAL SECURITY NO.</b> <b>220-44-5173</b>		
<b>17. INFORMANT</b> <b>Mrs. Evelyn Reuver, 1114 Ramblewood Rd, Balto.</b>			<b>ADDRESS</b>		
<b>18. 437.9 I</b> <b>CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
<b>(A) IMMEDIATE CAUSE</b> <i>arteriosclerotic cerebral</i> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <i>spinal vascular</i>					
<b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> _____					
<b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> _____					
<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <i>5 yrs</i>					
<b>MEDICAL CERTIFICATION</b>					
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>no</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>Oct 1936</i> <b>to</b> <i>Jan 17 1972</i> <b>that (I) (we) last saw the deceased alive on</b> <i>Jan 17 1972</i> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <i>Frederick J. Vollmer M.D.</i> <b>DEGREE</b>					<b>23B. DATE SIGNED</b> <b>1-18-72</b>
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Dr. Frederick J. Vollmer</b> <b>DEGREE</b>					<b>23D. ADDRESS</b> <b>6100 York Road, Balto, Md.</b>
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>burial</b>		<b>24B. DATE</b> <b>1/20/72</b>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Redeemer</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Md</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 20 1972</b>			
<b>25B. NAME OF REGISTRAR</b> <i>Robert E. Jones, M.D.</i>		<b>25C. FUNERAL DIRECTOR</b> <b>Leonard J. Guck, Inc. - Balto, Md.</b>			

Section 6. Schedule



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>K-400</b>		72 00642		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00642	
1. NAME OF DECEASED (Type or Print) <b>William Thomas Keell</b>				2. DATE AND HOUR OF DEATH <b>Jan. 17, 1972</b> <b>41</b> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 636 Archer St.</b>				4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2102</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>636 Archer St.</b>					
5. SEX <b>Male</b>		6. RACE <b>Colored</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/10/1899</b>		9. AGE (In years last birthday) <b>72</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Helper</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Transfare Co.</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>UNK.</b>				14. MOTHER'S MAIDEN NAME <b>UNK.</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>216-09-6092</b>		17. INFORMANT <b>Bernice V. Jones</b> ADDRESS <b>636 Archer St.</b>			
18. <b>412.3 J 185X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <b>Myocardial Failure</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>2 years</b> <b>3 years</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Prostate Cancer</b>									
19A. DATE OF OPERATION <b>21/1969</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Prostate</b>		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>5/23 1961</b> to <b>1/17 1972</b> that (I) (we) last saw the deceased alive on <b>1-16 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>John P. Urnoch Jr MD</b>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>1/19/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>JOHN P. URNOCH JR MD</b>				23D. ADDRESS <b>1227 Washington Blvd.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1972</b>		25B. NAME OF REGISTRAR <b>Charles A. Rice</b>		25C. FUNERAL DIRECTOR ADDRESS <b>661 W. Barre St.</b>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-400		72 00613		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00613	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Florence M Sewell			
2. DATE AND HOUR OF DEATH January 16 1972 1:50 PM				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 21223 2004				5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Bon Secours Hospital			
6. SEX Female		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. DATE OF BIRTH 05-29-02	
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME Mr. Louis Palmer	
14. MOTHER'S MAIDEN NAME Miss. Lillian Spence		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-05-2409		17. INFORMANT James Sewell 2517 W. Lombard St.	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH hours years			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 9, 1971 to Jan 15, 1972 that (I) (we) last saw the deceased alive on Jan 19, 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Baudeth				23B. DATE SIGNED 1-16-72			
23C. PHYSICIAN'S NAME (Type) BANDITH				23D. ADDRESS M.D. Bon Secours Hospital			
24A. BURIAL CREMATION REMOVAL (Specify) Burial		24B. DATE 1-20-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary		24D. LOCATION (City, town, or county) (State) Brooklyn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1972		25B. NAME OF REGISTRAR Robert E. Fisher		25C. FUNERAL DIRECTOR Charles H. Rice		ADDRESS 661 W. Barre St.	

1900 30

25 013

August 2 - 1900

92 30

1100

25 013 25 013 25 013 25 013

1900 30

August 2 - 1900

25 013 25 013 25 013 25 013

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00614</b>	
<b>W-426</b>		<b>72 00614</b>	
BIRTH NO.		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>WALKER, Medeshia</b>		2. DATE AND HOUR OF DEATH <b>1-16-72 - 4:07 pm</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1761</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>39 Provident Hospital</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		E. STREET AND NUMBER <b>539 Dolphin Street</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>02-10-85</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		9. AGE (in years last birthday) <b>86</b>	11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Wolford</b>		14. MOTHER'S MAIDEN NAME <b>Sarah</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>216-05-8577</b>	
17. INFORMANT <b>Vidella Lee</b>		ADDRESS <b>539 Dolphin St.</b>	
18. <b>4369 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Respiratory Arrest</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cerebrovascular Accident</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C)	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>0</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>C. G. F. Co. Md.</b>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>DEGREE</b>		23D. ADDRESS <b>DEGREE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-19-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Johnson</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>661 W. Barrre St.</b>	

1000 52

20

1000 52

1000 52

1000 52

C-600

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00645

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Walter Curry		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 18 Year 72 Hour 1:30A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2144 W. Fayette Street		3. DATE PRONOUNCED DEAD Month 1 Day 18 Year 72 Hour 1:30 A. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY 2002	
9. DATE OF BIRTH 2/4/81		10. AGE (In years last birthday) 50	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Chauffeur		15. MOTHER'S MAIDEN NAME Mary Diggs	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 219-03-4895	
18. INFORMANT Sireta Henry Curry		ADDRESS same	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 1-18-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/72	
24C. NAME OF CEMETERY or CREMATORY Arbutus Mem. Park		24D. LOCATION (City, town, or county) (State) Arbutus, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1972		25B. NAME OF REGISTRAR Robert E. Spitz, M.D.	
25C. FUNERAL DIRECTOR Charles A. Rice		ADDRESS 661 W. Barre St.	





REG. NO.

VS 151-REV. 7/1/68

11

100

(1)

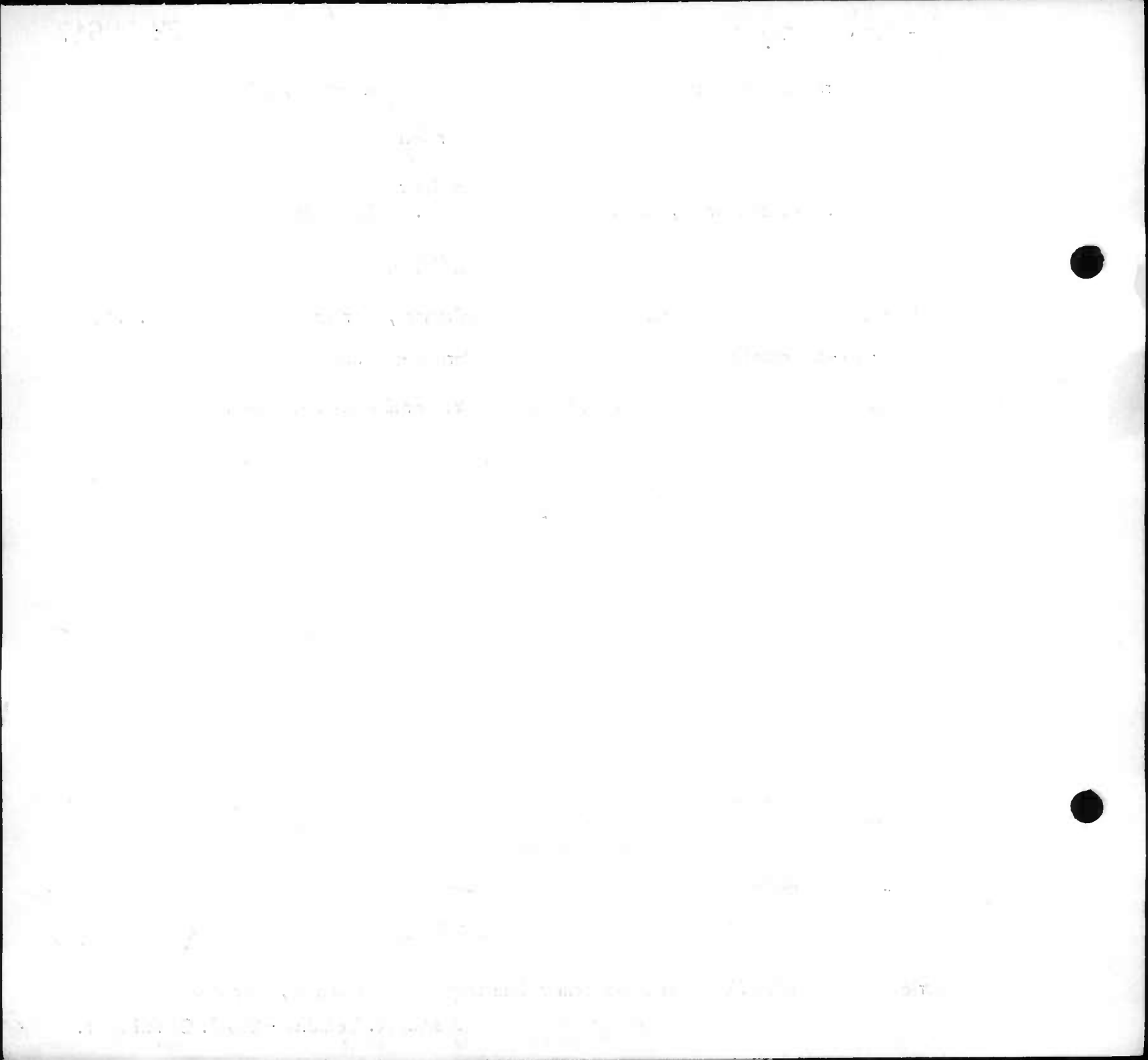
2000

5

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00647</u>
BIRTH NO. <u>L-250</u>		72 00647		
1. NAME OF DECEASED (Type or Print) <u>Maria Louise Luciano</u>		2. DATE AND HOUR OF DEATH <u>January 17, 1972</u> <u>6:00 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>443 S. Robinson Street, 21224</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>102</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>443 S. Robinson Street</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/5/1897</u>	9. AGE (In years last birthday) <u>74</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>
13. FATHER'S NAME <u>Pasquale Santella</u>		14. MOTHER'S MAIDEN NAME <u>Marianna Penna</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-10-4107 A</u>		17. INFORMANT ADDRESS <u>Mr. Carmine Luciano - same</u>
18. <u>412-3-1250-9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>ARTERIOSCLEROTIC HEART DISEASE</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>DIABETES MELLITUS</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs +</u>		
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>OCT 21, 1968</u> 19 to <u>JAN 17, 1972</u> that (I) <del>(was)</del> lost saw the deceased alive on <u>JAN 6, 1972</u> and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(was)</del> (did) <del>(did not)</del> view the body after death.				
23A. SIGNATURE <u>Melito M. Torres, M.D.</u>		23B. DATE SIGNED <u>JAN 20, 1972</u>		
23C. PHYSICIAN'S NAME (Type) <u>MELITO M. TORRES, M.D.</u>		23D. ADDRESS <u>441 S. ELLWOOD AVE 21224</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/22/72</u>	24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1972</u>		25B. NAME OF REGISTRAR <u>Joseph N. Zannino</u>		25C. FUNERAL DIRECTOR ADDRESS <u>263 S. Conkling St.</u>



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				72 00648		REG. NO.	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <i>Susie CLAYBORNE</i>			
2. DATE AND HOUR OF DEATH <i>11/19/72 1220 A.M.</i>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institutions residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1605</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>Balt City Hosp</i>				C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION <i>4940 Eastern Avenue 21224</i>				E. STREET AND NUMBER <i>2550 Harlem Avenue 21216</i>			
5. SEX <i>Female</i>	6. RACE <i>Negro</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2/22/12</i>	9. AGE (in years last birthday) <i>59</i>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S. A.</i>
13. FATHER'S NAME <i>Samuel Hall</i>			14. MOTHER'S MAIDEN NAME <i>Unknown</i>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give year or dates of service) <i>No</i>			16. SOCIAL SECURITY NO.		17. INFORMANT <i>4940 Eastern Ave</i>		ADDRESS <i>Baltimore, Maryland 21224</i>
18. <i>471X I</i>			CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Respiratory Arrest</i>				<i>17 hours</i>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) DUE TO, OR AS A CONSEQUENCE OF: <i>Pneumococcal Pneumonia</i>				<i>8 days</i>
			(C) <i>Upper Respiratory Infection (P.U.)</i>				<i>10 days</i>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH <i>Yes</i>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR			
22. I certify that (1) (this hospital) attended the deceased from <i>1/17</i> 19 <i>72</i> to <i>1/19</i> 19 <i>72</i> that (1) (we) last saw the deceased alive on <i>1/18/72</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>Daniel Tartaglia MD</i>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <i>1/19/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Daniel Tartaglia MD</i>				23D. ADDRESS <i>4940 Eastern Avenue 21224</i>			
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-22-72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt Auburn</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Md</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 20 1972</i>		25B. NAME OF REGISTRAR <i>Barbara E. ...</i>		25C. FUNERAL DIRECTOR <i>Edwards &amp; Brantley</i>			

1912

Received of  
the Treasurer  
of the  
Board of  
Education  
the sum of  
\$100.00  
for  
the year  
1912

1912  
1913  
1914  
1915  
1916  
1917  
1918  
1919  
1920  
1921  
1922  
1923  
1924  
1925  
1926  
1927  
1928  
1929  
1930  
1931  
1932  
1933  
1934  
1935  
1936  
1937  
1938  
1939  
1940  
1941  
1942  
1943  
1944  
1945  
1946  
1947  
1948  
1949  
1950  
1951  
1952  
1953  
1954  
1955  
1956  
1957  
1958  
1959  
1960  
1961  
1962  
1963  
1964  
1965  
1966  
1967  
1968  
1969  
1970  
1971  
1972  
1973  
1974  
1975  
1976  
1977  
1978  
1979  
1980  
1981  
1982  
1983  
1984  
1985  
1986  
1987  
1988  
1989  
1990  
1991  
1992  
1993  
1994  
1995  
1996  
1997  
1998  
1999  
2000  
2001  
2002  
2003  
2004  
2005  
2006  
2007  
2008  
2009  
2010  
2011  
2012  
2013  
2014  
2015  
2016  
2017  
2018  
2019  
2020  
2021  
2022  
2023  
2024  
2025  
2026  
2027  
2028  
2029  
2030  
2031  
2032  
2033  
2034  
2035  
2036  
2037  
2038  
2039  
2040  
2041  
2042  
2043  
2044  
2045  
2046  
2047  
2048  
2049  
2050  
2051  
2052  
2053  
2054  
2055  
2056  
2057  
2058  
2059  
2060  
2061  
2062  
2063  
2064  
2065  
2066  
2067  
2068  
2069  
2070  
2071  
2072  
2073  
2074  
2075  
2076  
2077  
2078  
2079  
2080  
2081  
2082  
2083  
2084  
2085  
2086  
2087  
2088  
2089  
2090  
2091  
2092  
2093  
2094  
2095  
2096  
2097  
2098  
2099  
2100

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 00649</span>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">72 00649</span>	
1. NAME OF DECEASED (Type or Print) <b>JOHN BURRELL</b>			2. DATE AND HOUR OF DEATH <b>1-17-72 5:03 PM</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>33 JOHNS HOPKINS HOSPITAL</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>909</b>		
			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>1317 AISOUTH STREET</b>		
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>08/18/96</b>	9. AGE (In years last birthday) <b>75</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>	
13. FATHER'S NAME <b>Isaac Burrell</b>		14. MOTHER'S MAIDEN NAME <b>Janet ?</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>W</b>		16. SOCIAL SECURITY NO. <b>215 09 4900</b>		17. INFORMANT <b>Ella Burrell Jones</b>	
18. <b>441.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIAC ARREST</b> (B) <b>probable Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>possible Aortic Dissecting Aneurysm</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-16-72</b> 19__ to <b>1-17-72</b> 19__ that (I) (we) last saw the deceased alive on <b>1-17-72</b> 19__ and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>M. Horan MD</b>				23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>M. HORAN MD</b>				23D. ADDRESS <b>Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
<b>Buried</b>		<b>1-22-72</b>		<b>Not Auburn Cal</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
<b>JAN 20 1972</b>		<b>Reece</b>		<b>21205</b>	
VS 150-REV. 1/1/68					

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917

1917



# FUNERAL DIRECTOR: IMPORTANT

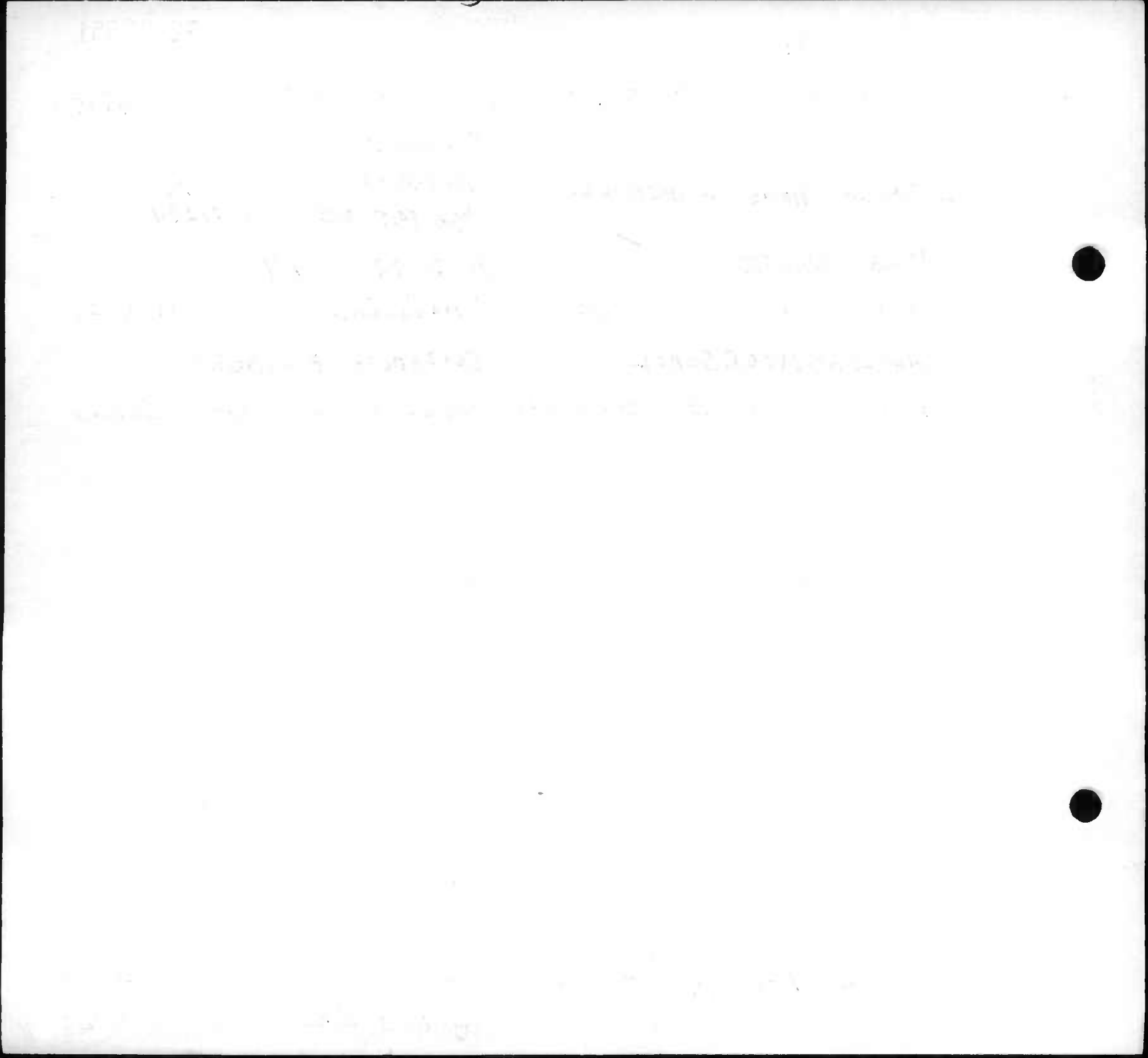
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>42-635</u> <u>72 00650</u>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 00650</u>	
1. NAME OF DECEASED (Type or Print) <u>Julia E. Wharton</u>				2. DATE AND HOUR OF DEATH <u>January 15, 1972</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>18 Mary Land Mem. Hosp.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1601</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>18 Mary Land Mem. Hosp.</u>				C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>1029 Harbor Ave</u>							
5. SEX <u>Female</u>	6. RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 17, 1911</u>	9. AGE (In years lost birthday) <u>60</u>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>James H. Fletcher</u>				14. MOTHER'S MAIDEN NAME <u>Sarah F. Eber</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-14-7426</u>		17. INFORMANT <u>Clifford Wharton</u>		ADDRESS <u>Same</u>	
18. <u>410.9x1250.9</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Agut coronary Occlusion</u> <u>Atherosclerosis</u> <u>Diabetes Mellitus</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u> <u>9 months</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>6-28</u> 1971 to <u>1-15</u> 1972, that (I) <del>(we)</del> last saw the deceased alive on <u>10-25</u> 1971 and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) (did not) view the body after death.							
23A. SIGNATURE <u>William H. Watson</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/20/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>William H. Watson</u>				23D. ADDRESS <u>515 N. Washington</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-19-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Career Memorial Park</u>		24D. LOCATION <u>Lanham Md</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1972</u>		25B. NAME OF REGISTRAR <u>Robert J. Z...</u>		25C. FUNERAL DIRECTOR <u>Burial...</u>		ADDRESS <u>1029 Broadway Ave</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
M-624		72 00651		72 00651	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
MOERSCHER, MR. CHARLES, R.		JAN. 19, 1972. 1:10 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY			
CHURCH HOME & HOSPITAL		MARYLAND			
5. SEX		6. RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
MALE		WHITE		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH		9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
11-21-22		49		RESTAURANT	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME	
BALTIMORE, MARYLAND		U. S. A.		CHARLES M. MOERSCHER	
14. MOTHER'S MAIDEN NAME		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
ELIZABETHA. BERTSCHER		YES		216-18-9681	
17. INFORMANT		18. CAUSE OF DEATH		ADDRESS	
STELLA V. MOERSCHEL		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		Same	
		Cardio-respiratory failure		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		(A) IMMEDIATE CAUSE		Sec. No.	
		DUE TO, OR AS A CONSEQUENCE OF:			
		Increase Hemorrhage		No.	
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) No Berry Anomalous, Pyloric			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
D				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-19-72 to 1-19-72 that (I) (we) last saw the deceased alive on 1-19-72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type)	
Ma. Elena V. Mangay		1-19-72		MA. ELENA V. MANGAY	
23D. ADDRESS		24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
100 N Broadway Baltimore Md.		BURIAL		1-22-72	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county)		24E. NAME OF REGISTRAR	
OAK LAWN CEM.		7225 EASTERN BLVD, BALTO. CO., MD.		Robert E. Taylor	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 20 1972		Charles A. Guler		901 S. CONKLING ST. BALTO., 21224, MD.	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00652

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>GEORGE L. WACHTER</b> George Wachter		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 18 72 1:00 A. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 Wooded area - 201 Kane St. Balto., 21224, Md.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 18 72 1:00 A. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Queen Annes 6700</b>	
9. DATE OF BIRTH <b>Aug. 11, 1948</b>		10. AGE (In years last birthday) <b>23</b>	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Louis A. Wachter</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unemployed</b>	
15. MOTHER'S MAIDEN NAME <b>Pearl A. Schoff</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>214-50-4890</b>		18. INFORMANT <b>Louis A. Wachter</b>	
19. <b>E955X</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTecedent CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Wooded area</b>	
22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <b>201 Kane Street 2605</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>1 18 72 12:27 A.M.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>shot self in head</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED <b>1-18-72</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-72.</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>7225 Eastern Blvd., Ba. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, R.R.</b>	
25C. FUNERAL DIRECTOR <b>Charles S. Gerber</b>		25D. ADDRESS <b>901 S. Conkling St. Balto., 21224, Md.</b>	

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

1950-55

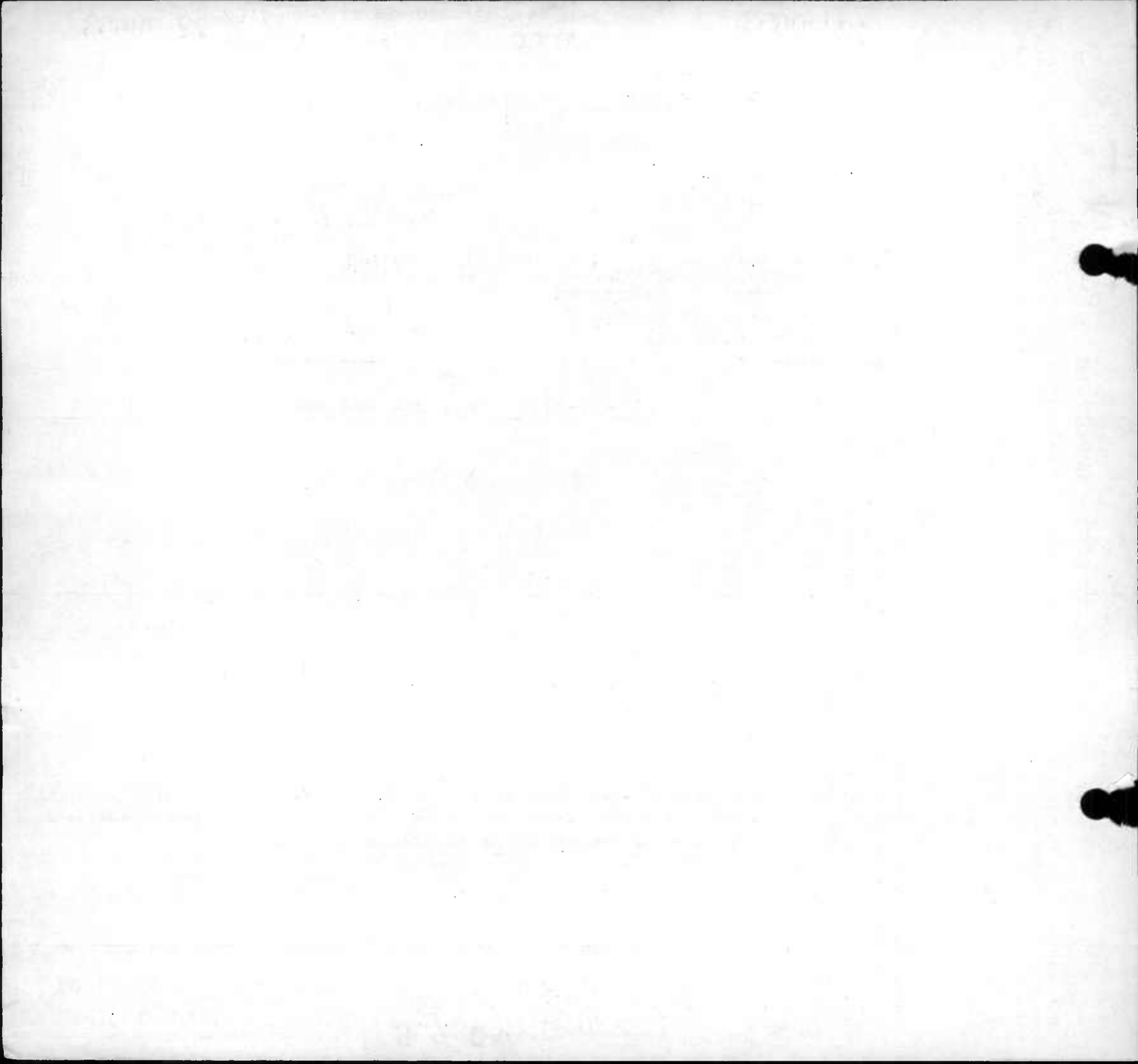
1950-55

1950-55

1950-55

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00653</u>
72 00653				CERTIFICATE OF DEATH
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Peter P. Sadowski</u>		2. DATE AND HOUR OF DEATH <u>Jan. 18, 1972</u>   <u>9<sup>30</sup></u> <u>P</u> M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>264-1</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>44 Union Memorial Hospital</u> <u>33rd &amp; Calvert Sts.</u>		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>4337 Berger Ave.</u>				
5. SEX <u>Male</u>	6. RACE <u>Caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 23, 1906</u>	9. AGE (In years last birthday) <u>75</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Launchman</u> <u>Ship Repair</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>unknown - Sadowski</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>
16. SOCIAL SECURITY NO. <u>218-09-5720</u>		17. INFORMANT <u>Mrs. Irma Sadowski, 4337 Berger Ave</u>		
18. <u>162.1</u> I		CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <u>perforated viscous</u> DUE TO, OR AS A CONSEQUENCE OF:		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>metastatic carcinoma (abdomen)</u> DUE TO, OR AS A CONSEQUENCE OF:		
(C) <u>carcinoma of @ lung</u>				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <u>10-1-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>carcinoma @ lung</u>		20A. AUTOPSY? (Yes or No) <u>No</u>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 18 1972</u> to <u>Jan 18 1972</u> , that (I) (we) last saw the deceased alive on <u>Jan 18 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Robert Gunneth</u>		23B. DATE SIGNED <u>Jan 18, 1972</u>		
23C. PHYSICIAN'S NAME (Type) <u>R Gunneth</u>		23D. ADDRESS <u>UMH</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/21/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Holy Rosary</u>
24D. LOCATION <u>Baltimore, Maryland</u>				
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 20 1972</u>		25B. NAME OF REGISTRAR <u>Robert Gunneth</u>		25C. FUNERAL DIRECTOR <u>M.F. SADOWSKI &amp; SONS, 1808 EASTERN AVE</u>

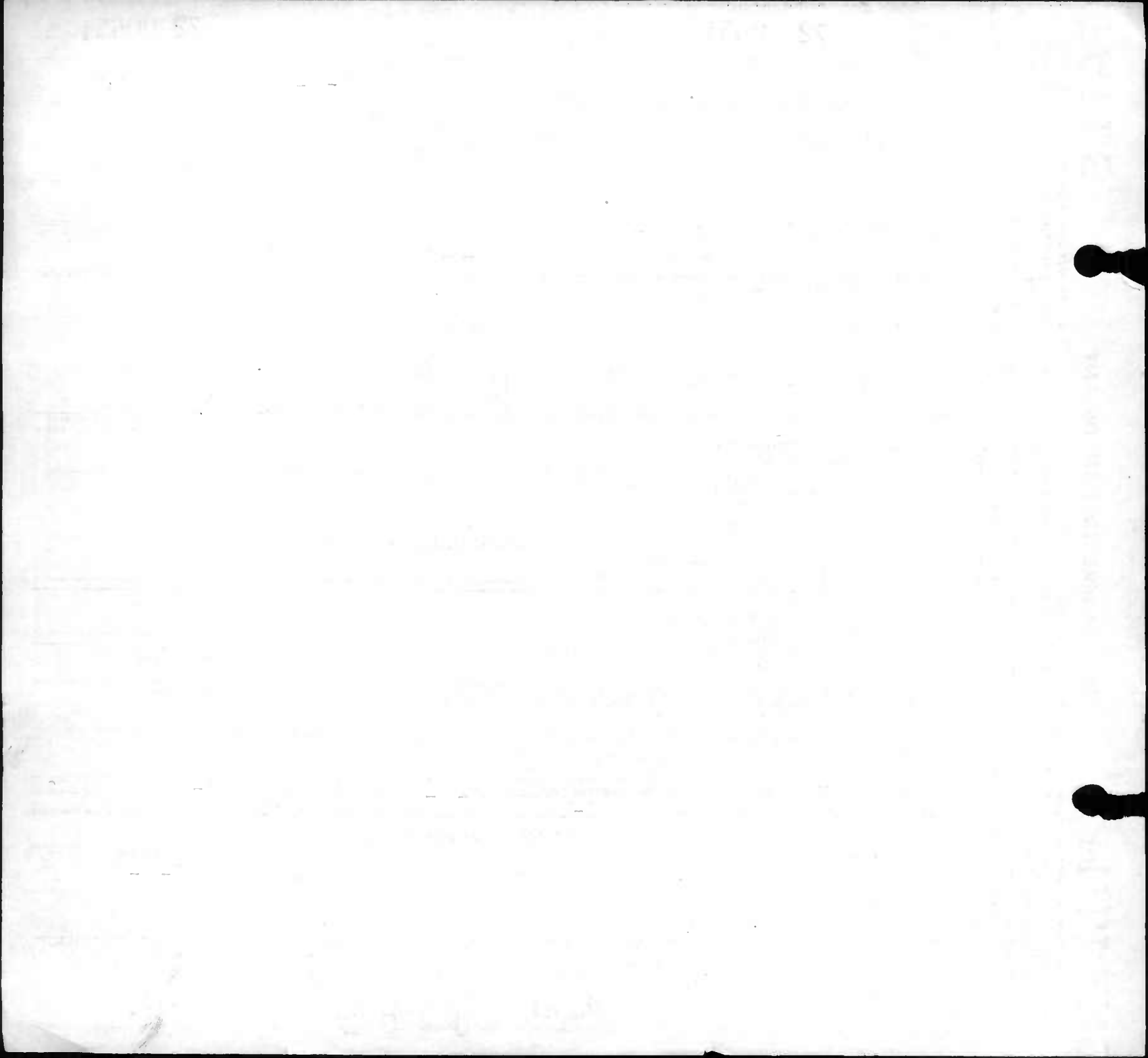




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620 72 00654		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00654	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Gertrude E. Briscoe		1-18-72 3:30 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		A. STATE		B. COUNTY	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		Maryland		2719	
37 Mercy Hospital, Inc.		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER			
		2908 Manhattan Ave #21215			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
Female	Negro	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	4-9-23	48	11. Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Clerk		Post Office		Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
Oliver Christmas		Ida Mason			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
		216-16-6580		Mr. Oliver Christmas 828 Brooks Lane	
18. 436.0 I		CAUSE OF DEATH		ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		CVA		2h	
ANTECEDENT CAUSES		(B) Hypertension		years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examination)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-18-72 to 1-18-72 that (I) (we) last saw the deceased alive on 1-18-72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Tolm OHE MD				1-18-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Tolm OHE MD				Mercy Hospital	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1-21-72		Mt. Lebanon Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 20 1972		R. E. Taylor M.D.		Joseph L. Jones 2122 N. Hollman	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

95-11022

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K532 72 00656		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00656	
BIRTH NO.		CERTIFICATE OF DEATH		2. DATE AND HOUR OF DEATH JANUARY 16 1972 6:50 P M.	
1. NAME OF DECEASED (Type or Print) KOONTZ, ESTELLA MA		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY MD. HOWARD COUNTY 6300			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL WILKENS & CATON AVENUES BALTIMORE, MARYLAND 21229		C. CITY OR TOWN ELLICOTT CITY		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10B. KIND OF BUSINESS OR INDUSTRY At Home		8. DATE OF BIRTH 10 18 94	
13. FATHER'S NAME SILAS SISK		14. MOTHER'S MAIDEN NAME SARAH (PHELPS) SISK		9. AGE (In years last birthday) 77	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 213-09-6044D		11. BIRTHPLACE (State or foreign country) MARYLAND	
18. <u>4127</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		12. CITIZEN OF WHAT COUNTRY? UNITED STATES		17. INFORMANT ST. AGNES HOSPITAL MEDICAL RECORDS	
19. DATE OF OPERATION 0		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>JANUARY 12</u> 19 <u>72</u> to <u>JANUARY 16</u> 19 <u>72</u> that <u>(u)</u> (we) last saw the deceased alive on <u>JANUARY 16</u> 19 <u>72</u> and that in <u>(u)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) <u>(not)</u> view the body after death.					
23A. SIGNATURE <u>77 Mol</u>		23B. DATE SIGNED <u>1-16-72</u>		23C. PHYSICIAN'S NAME (Type) DR. JACOBUS MOL	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/72		24C. NAME OF CEMETERY or CREMATORY Good Shepherd Cem.	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1972		25B. NAME OF REGISTRAR <u>James E. [unclear]</u>		25C. FUNERAL DIRECTOR Black, Funeral Home, Ellicott City, Md 21043	
24D. LOCATION Ellicott City		24E. LOCATION Maryland		24F. LOCATION Maryland	

25 AUG 58

105

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT:

RE: [illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

[illegible]

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-256 72 00657				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00657	
BIRTH NO.				DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>KAY WAGNER</b>				DATE <b>01-17-72</b> TIME <b>8:15 P.</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2831</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205</b>				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>6502 EBERLE DRIVE, APT. 304</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>02-28-11</b>	9. AGE (In years last birthday) <b>60</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>SHAMPOO GIRL</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>STEWARTS</b>		11. BIRTHPLACE (State or foreign country) <b>POLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOSEPH GOODMAN</b>				14. MOTHER'S MAIDEN NAME <b>MOLLIE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MR. CARL WAGNER, 6502 EBERLE DR., APT. 304 #15</b>			
18. CAUSE OF DEATH <b>412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>VENTRICULAR FAILURE</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>CORONARY ARTERY DISEASE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 yr</b> <b>2 yr</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Mostly medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>1/9</b> 19 <b>72</b> to <b>1/17</b> 19 <b>72</b> that (2) (we) last saw the deceased alive on <b>1/17</b> 19 <b>72</b> and that (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>W. Rohde M.D.</b>				23B. DATE SIGNED <b>1/17/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>WILLIAM A. ROHDE M.D.</b>				23D. ADDRESS <b>601 N. Broadway Baltimore</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-18-72</b>		24C. NAME of CEMETERY or CREMATORY <b>AHAVAS SHALOM</b>		24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1972</b>		25B. NAME OF REGISTRAR <b>W. A. Rohde</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

10-11-70

10-11-70

10-11-70

10-11-70

10-11-70

10-11-70

10-11-70

10-11-70

10-11-70

10-11-70

10-11-70

10-11-70

10-11-70

10-11-70

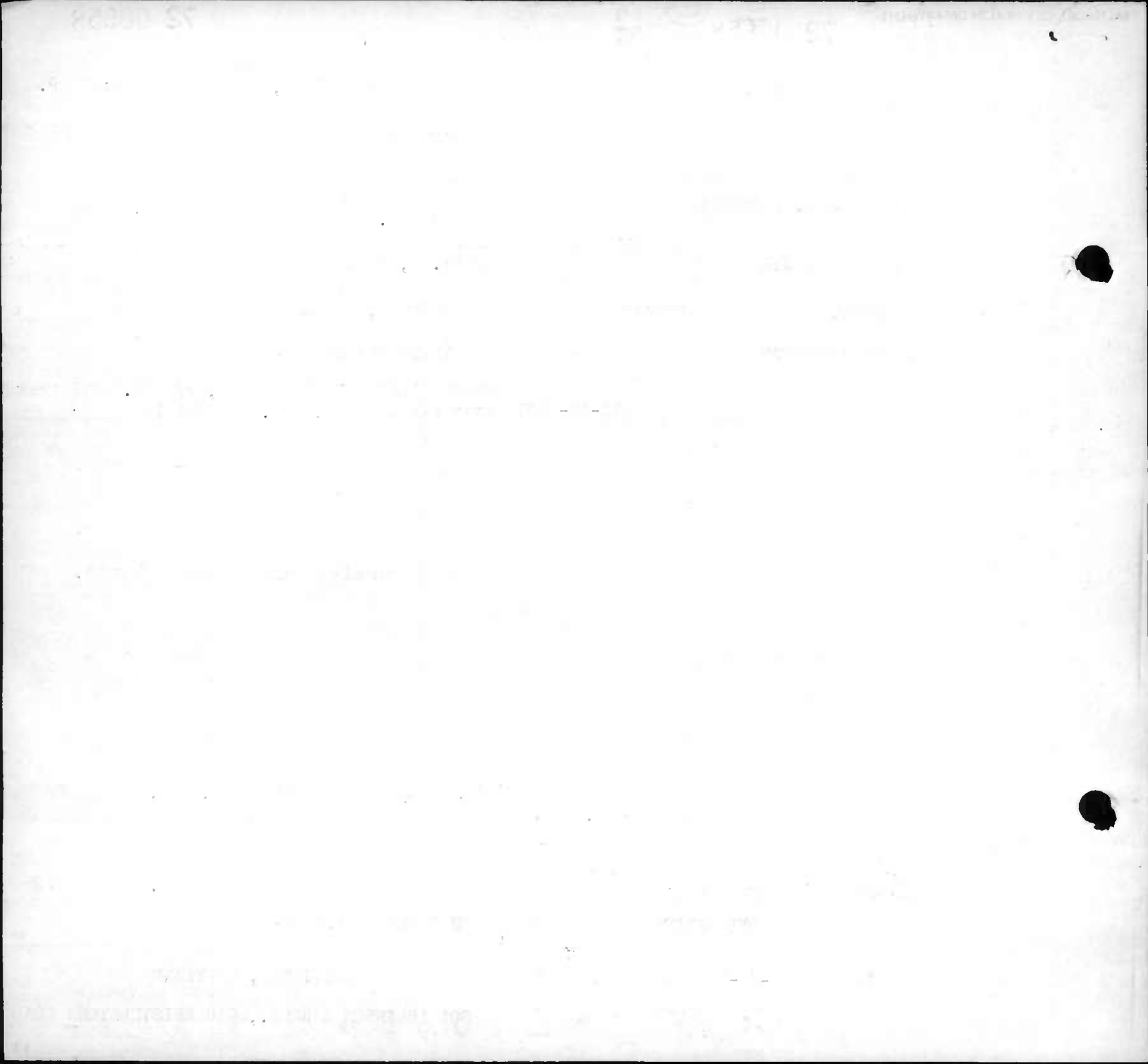
10-11-70



# FUNERAL DIRECTOR: IMPORTANT

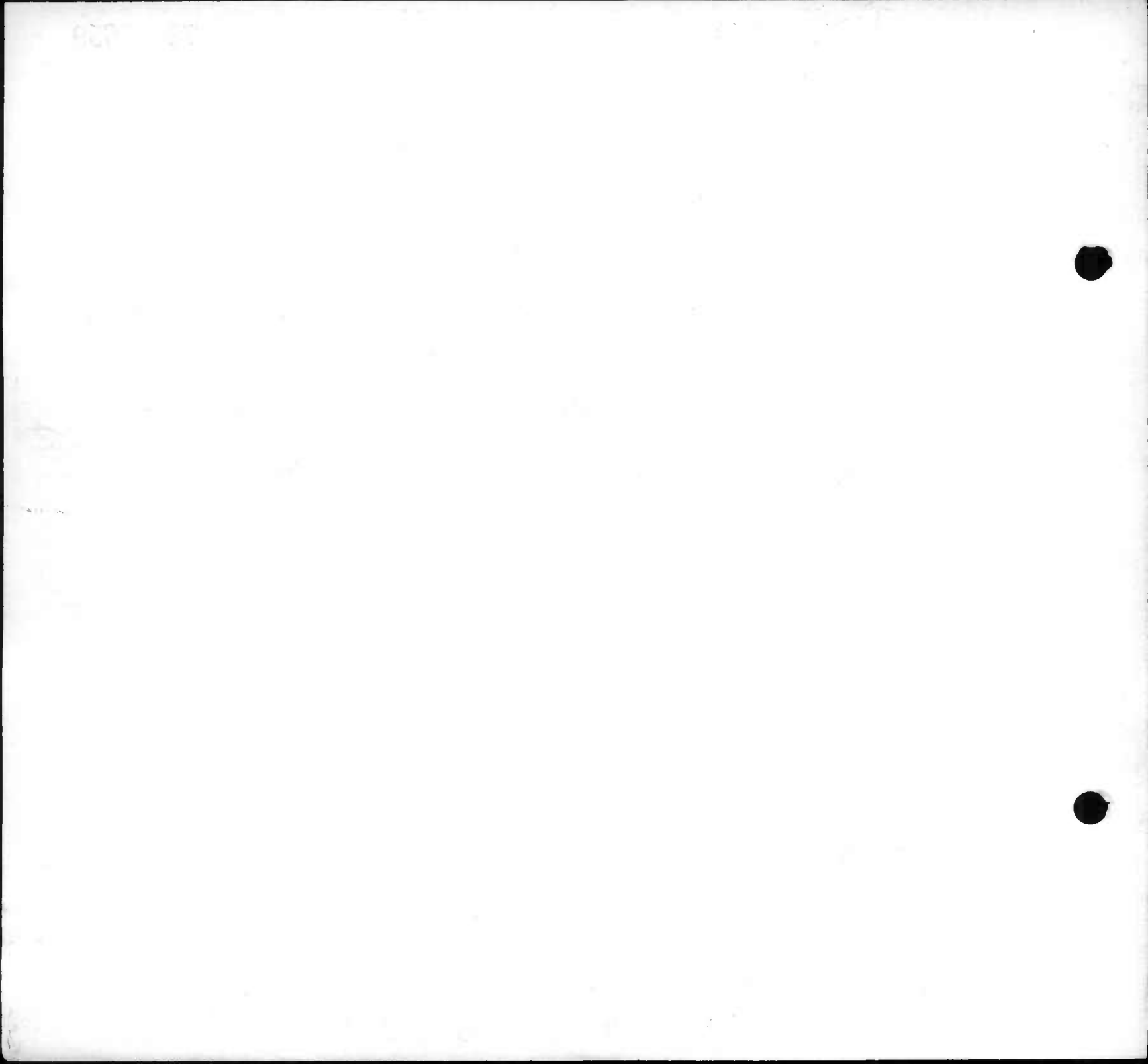
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00658	
BIRTH NO. 72 00658		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) NATHAN HOUSEMAN			2. DATE AND HOUR OF DEATH JANUARY 15, 1972 4:45 P. M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) ARDLEIGH NURSING HOME 2095 ROCKROSE AVENUE			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3931 MT. PLEASANT AVENUE #21224		
5. SEX MALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 6, 1911	9. AGE (In years last birthday) 60	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY RETAIL		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
13. FATHER'S NAME JACOB HOUSEMAN			14. MOTHER'S MAIDEN NAME YETTA CRAMER		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 212-16-9537		17. INFORMANT ADDRESS HEBREW FREE BURIAL SOCIETY, c/o MR. MOSE MORRIS 3737 CLARKS LANE, APT. 101 #21215	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Chronic alcoholism			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic cardiovascular disease 5 yrs. (B) Cirrhosis of liver 3 yrs. (C) Chronic obstructive pulmonary disease 5 yrs. Chronic alcoholism ?		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (his hospital) attended the deceased from Oct. 20, 1971 to Jan. 15, 1972, that (I) (we) lost saw the deceased alive on Jan. 15, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Lloyd C. Saylor M.D.				23B. DATE SIGNED Jan. 17, 1972	
23C. PHYSICIAN'S NAME (Type) LLOYD SAYLOR		23D. ADDRESS 3002 GREENMOUNT AVENUE			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL		24B. DATE 1-18-72		24C. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW	
24D. LOCATION (City, town, or county) BALTIMORE, MARYLAND		24E. (State)			
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1972		25B. NAME OF REGISTRAR Philip E. Taylor M.D.		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print) <b>GEORGE HURNEY</b>		2. DATE AND HOUR OF DEATH <b>1/14/72 9:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>SINAI HOSPITAL of BALTIMORE</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2802</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>SINAI HOSPITAL of BALTIMORE</b>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>5210 GUYMON OAK AVE.</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUC</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3/30/09</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANAGER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>RED HIND OIL CO.</b>	9. AGE (in years last birthday) <b>62</b>
11. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MICHAEL HURNEY</b>		14. MOTHER'S MAIDEN NAME <b>AGNES Mc MAHON</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>211-05-9002</b>	17. INFORMANT <b>SLATER FUNERAL HOME, INC.</b>
18. <b>485X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>BRONCHOPNEUMONIA</b> DUE TO, OR AS A CONSEQUENCE OF: <b>ASPIRATION (?)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 DAYS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>CVA (?) MRDINGITUS (?)</b>			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/6/72</b> 19 to <b>1/14/72</b> 19 that (I) (we) last saw the deceased alive on <b>1/14/72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>ARNOLD T. ORDINARIO JR.</b>		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>ARNOLD T. ORDINARIO JR. M.D.</b>		23D. ADDRESS <b>SINAI HOSPITAL of BALTIMORE</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-19-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>GALLERY CEMETERY</b>		24D. LOCATION (City, town, or county) (State) <b>PITTSBURGH, PENNSYLVANIA</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Wm. C. C. Brooks</b>		ADDRESS <b>Towson, Md.</b>	

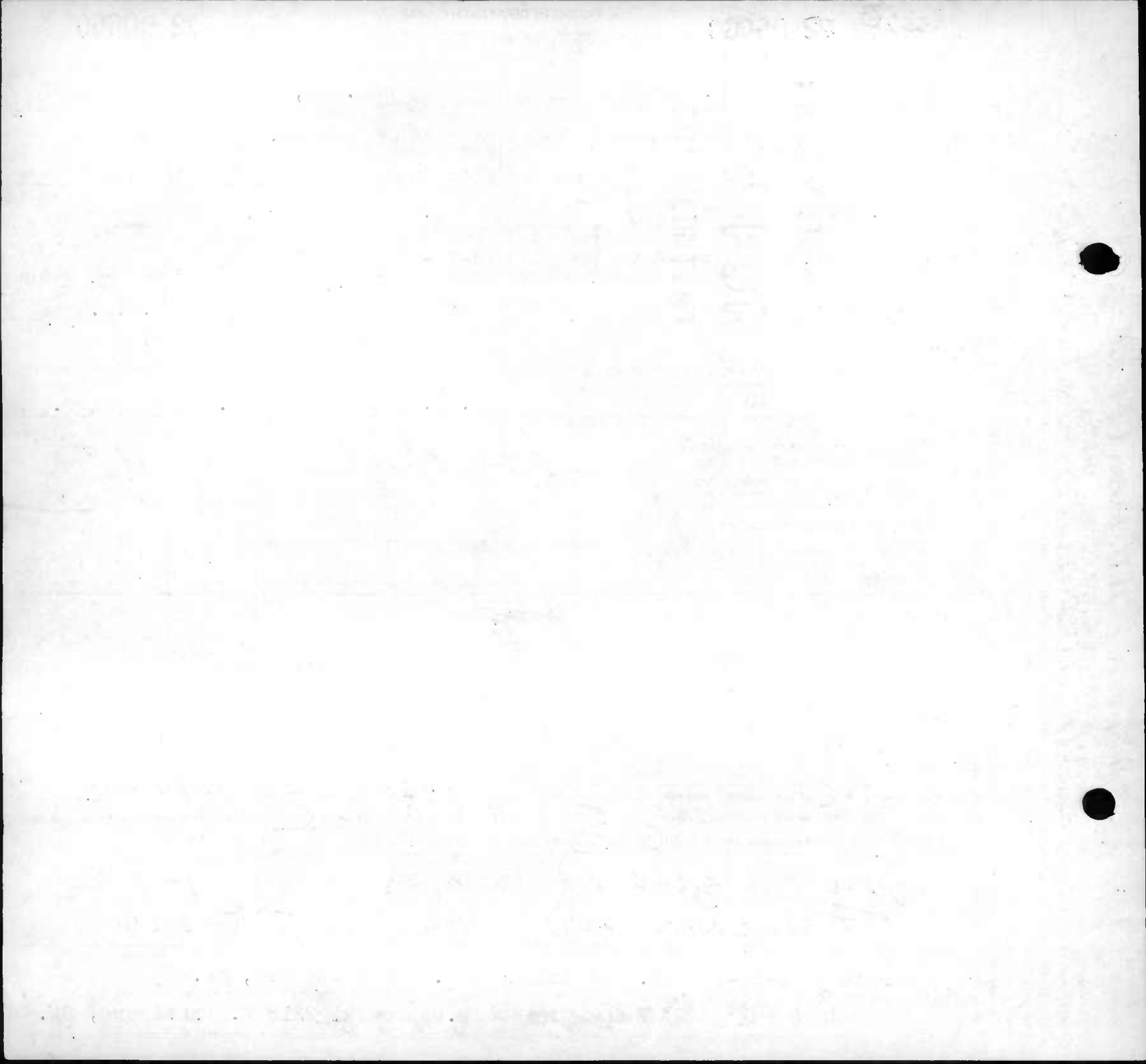


Cleared to Med. Exam Office 1-14-72

VIA Telephone - University of Maryland  
FURNAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-256 72 00660		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00660	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Joseph P. Kaczmarek			
2. DATE AND HOUR OF DEATH Jan. 14, 1972		M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION 00 28 N. Lakewood Ave.		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland Balto. 602 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 28 N. Lakewood Ave.			
5. SEX Male	6. RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-10-1901	9. AGE (In years last birthday) 70	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Blacksmith		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME John		14. MOTHER'S MAIDEN NAME Mary	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT Mr. J. Kaczmarek 28 N. Lakewood ave.	
18. 412.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		CAUSE OF DEATH Gen ASCU (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10+			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1960 to 1-14-72, that (I) (we) last saw the deceased alive on 5-7-71 and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Theo T. Niznik M.D.		23B. DATE SIGNED 1-17-72		23C. PHYSICIAN'S NAME (Type) THEO T. NIZNIK M.D.	
23D. ADDRESS 429 5th St 21231		23E. NAME OF REGISTRAR B. Dabrowski		23F. FUNERAL DIRECTOR B. Dabrowski	
24A. BURIAL, CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-18-72		24C. NAME OF CEMETERY or CREMATORY St. Stanislaus Cem.	
24D. LOCATION Baltimore, Md.		24E. DATE REC'D BY HEALTH DEPT. JAN 20 1972		24F. NAME OF REGISTRAR B. Dabrowski	
24G. ADDRESS 2818 E. Baltimore, St.		24H. DATE 1-14-72		24I. NAME OF REGISTRAR B. Dabrowski	



FUNERAL DIRECTOR: IMPORTANT

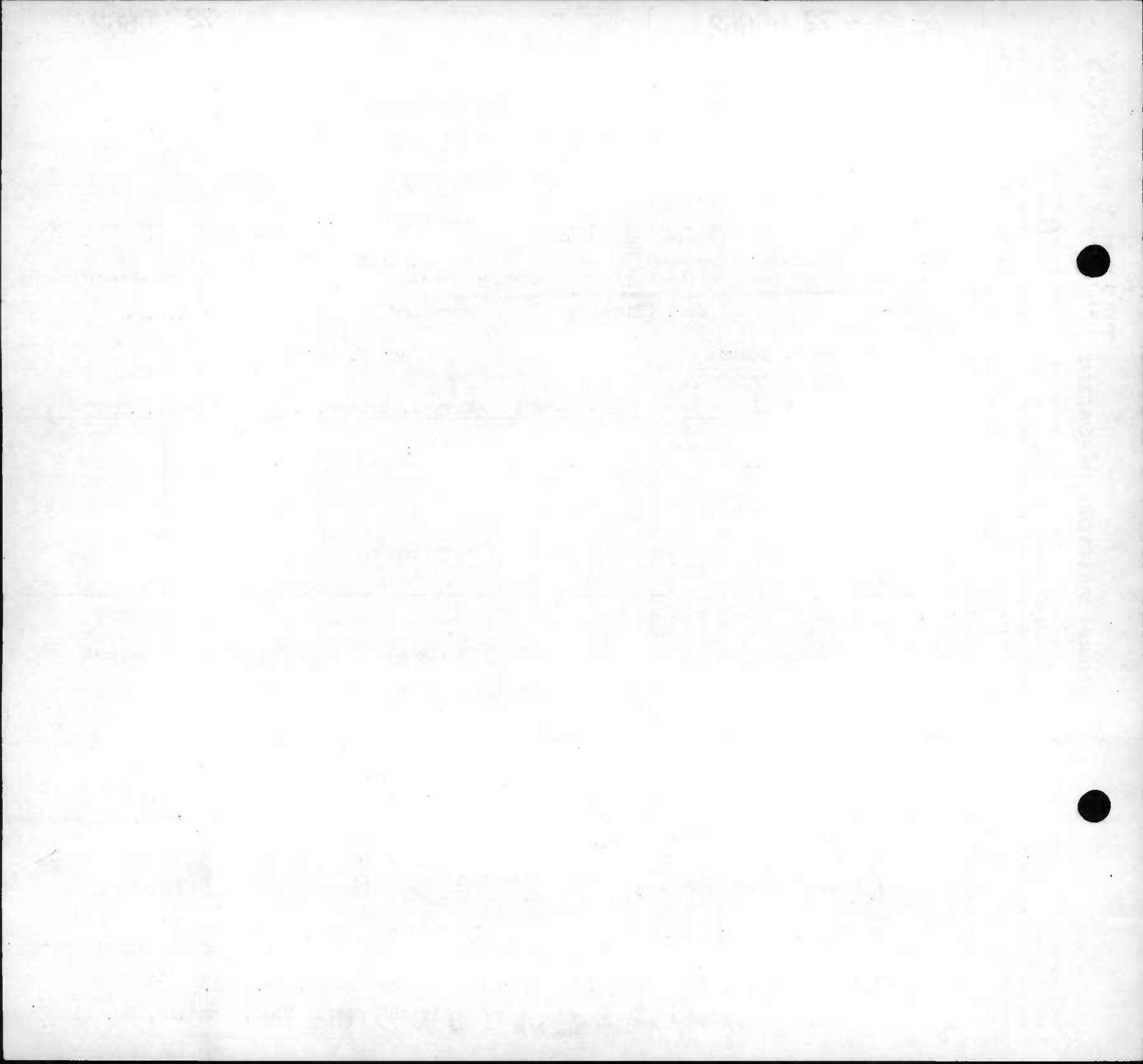
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00661</b>	
D-630 72 00661		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Dorrett, Norman</b>	
2. DATE AND HOUR OF DEATH <b>1/17/72 1:00 P.M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION <b>The Good Samaritan Hospital 45</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2636</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>6723 Pine Avenue</b>		5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>9/26/01</b> 9. AGE (In years last birthday) <b>70</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>galv. pipe mill wrkr.</b> 10B. KIND OF BUSINESS OR INDUSTRY <b>Steel</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Thomas Dorrett</b> 14. MOTHER'S MAIDEN NAME <b>Ella Warner</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-07-7655</b> 17. INFORMANT ADDRESS <b>Mrs. Henrietta Dorrett, 6723 Pine Ave. 21222</b>	
18. <b>492X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Emphysema</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>cor pulmonale</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Large ext hemorrhoid</b>			
19A. DATE OF OPERATION <b>0</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>H. Goldberg, M.D.</b> attended the deceased from <b>1968</b> to <b>present</b> that (I) (we) last saw the deceased alive on <b>1/17 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>H. Goldberg, M.D.</b> 23B. DATE SIGNED <b>1/17/72</b>		23C. PHYSICIAN'S NAME (Type) <b>H. Goldberg, M.D.</b> 23D. ADDRESS <b>5601 Loch Raven Blvd. 21239</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>burial</b> 24B. DATE <b>20 Jan 72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b> 24D. LOCATION (City, town, or county) (State) <b>Balto. Co., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 20 1972</b> 25B. NAME OF REGISTRAR <b>John E. Jones, Jr.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Olloch Funeral Home, Dundalk, Md. 21222</b>	





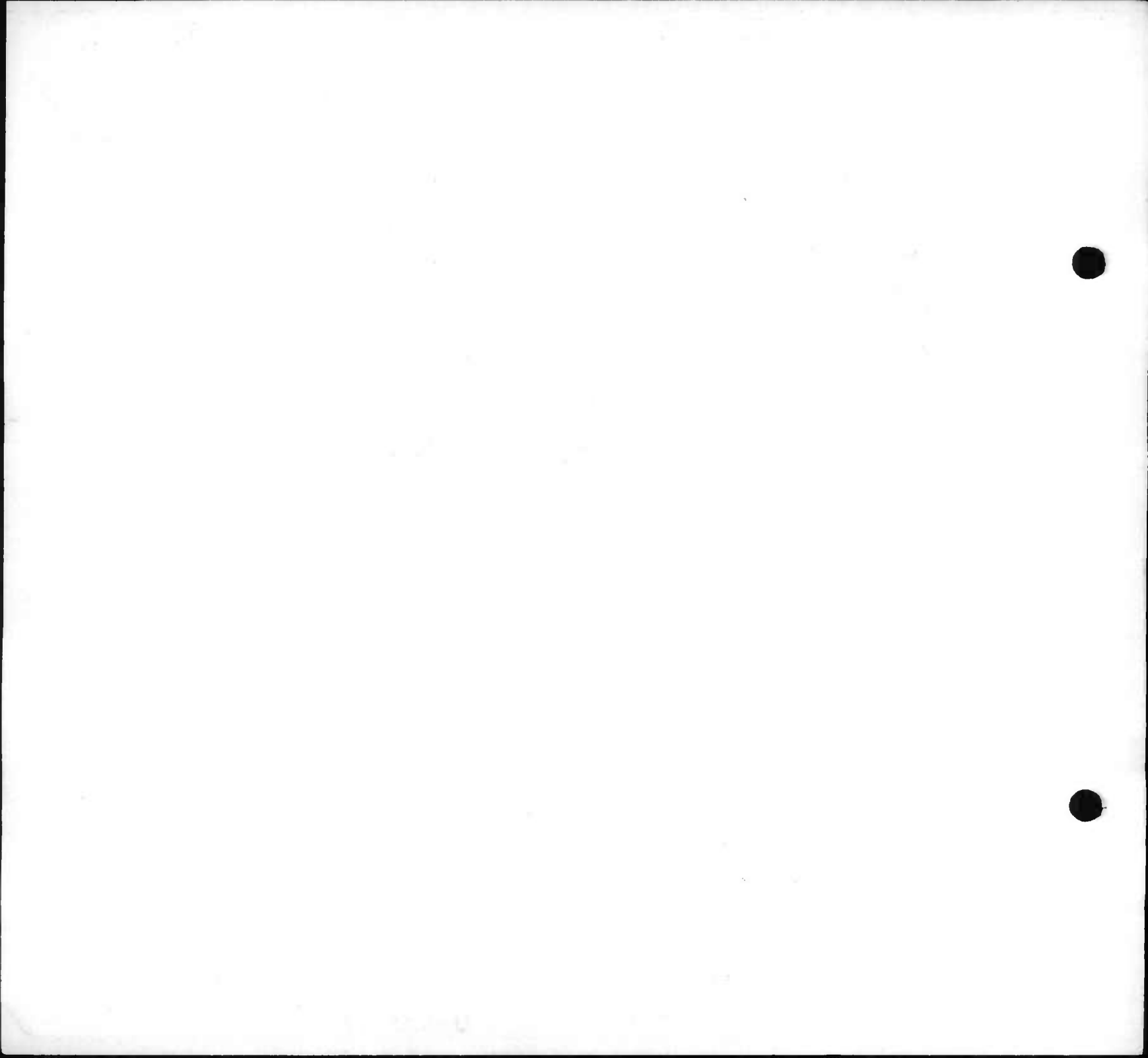
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased deceased prior to death; and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

14-400 72 00663		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 72 00663	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>HALL, Flora</i>		2. DATE AND HOUR OF DEATH <i>1-16-72 6:40 p.m.</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>1605</i>		C. CITY OR TOWN <i>Baltimore</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>46 Lutheran</i>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <i>F</i>		6. RACE <i>C</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>6-6-1918</i>	
13. FATHER'S NAME <i>unk.</i>		14. MOTHER'S MAIDEN NAME <i>unk.</i>		9. AGE (in years last birthday) <i>53</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>no</i>		16. SOCIAL SECURITY NO. <i>220-22-9168</i>		11. BIRTHPLACE (State or foreign country) <i>Anderson, South Carolina</i>	
17. INFORMANT <i>Mr. Dennis Hall</i>		ADDRESS <i>Mrs. Ann Barber 2614 W. Lafayette Ave.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
18. <i>4109 I</i>		CAUSE OF DEATH <i>Acute Myocardial Infarction</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>1/16/1972</i> to <i>1/16/1972</i> that (I) (we) last saw the deceased alive on <i>1/16/1972</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Arjana Doshi M.D.</i>		23B. DATE SIGNED <i>1/16/72</i>		23C. PHYSICIAN'S NAME (Type) <i>ARJANA DOSHI M.D.</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-22-1972</i>		24C. NAME OF CEMETERY or CREMATORY <i>Mt. Calvary Cemetery</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 20 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. Feltz M.D.</i>		25C. FUNERAL DIRECTOR <i>Burnell B. Ioden</i>	
24D. LOCATION (City, town, or county) (State) <i>A.A. Co., Maryland</i>		1735 Harford Ave. 22113			



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00664

BIRTH NO.

1. NAME OF DECEASED (Type or Print) BEATRICE HENDRICKS PRICE (Thelma-Theodora)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 2202 Barclay St. 3-13-72		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 16 1972 10:03 am	
6. SEX female		7. RACE negro	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Balto.	
9. DATE OF BIRTH 10-23-1945		10. AGE (in years last birthday) 26	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		15. MOTHER'S MAIDEN NAME Queen M. Hendricks	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) no		17. SOCIAL SECURITY NO. 219-42-7003	
18. INFORMANT Mr. Edward Price 2202 Barclay St. 21218 Mr. & Mrs. Leroy (Queen) Hendricks 1418 N. CALLETON AVE.		ADDRESS	
19. 493X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Acute bronchopneumonia Pulmonary insufficiency ASTHMA AND RHEUMATIC HEART DISEASE ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CAUSATION LAST.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Asthma and rheumatic heart disease DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: Russell S. Fisher, M.D. EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-21-1972	
24C. NAME OF CEMETERY or CREMATORY Arbutus Memorial Pk. Inc.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 20 1972 Robert E. Fisher, M.D.		25B. NAME OF REGISTRAR Marshall W. Jones, Jr.	
25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213		ADDRESS	

3-13-1972 - Letter - Office of the Chief Medical Examiner

Russell S. Fisher, M.D.  
Chief Medical Examiner

HRS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00665</b>	
S-315-72 00665		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>D. Margaret Stevenson</b>	
2. DATE AND HOUR OF DEATH <b>1-19-72 10:35 PM</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>37 Mercy Hospital, Inc.</b>	
4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 Mercy Hospital, Inc.</b>	
C. CITY OR TOWN <b>Dundalk</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
E. STREET AND NUMBER <b>2612 Liberty Parkway</b>		5. SEX <b>Female</b> 6. RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1-17-18</b> 9. AGE (in years last birthday) <b>54</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretary</b>	
11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Earl Strickler</b>		14. MOTHER'S MAIDEN NAME <b>Alta Riley</b>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-09-0877</b>	
17. INFORMANT <b>Sister: Mrs. Helen S. Low</b>		ADDRESS <b>2400 Church Hill Road Silver Springs, Md. 20902</b>	
18. <b>154.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Diffuse Carcinomatosis with Jaundice</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Adenocarcinoma of Rectum</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from <b>1-19</b> <b>19 72</b> to <b>1-19-72</b> <b>19</b> that (B) (we) lost saw the deceased alive on <b>1-19</b> <b>19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Wayne Lee</b>		23B. DATE SIGNED <b>1-20-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>DR. Wong Lee</b>		23D. ADDRESS <b>Mercy Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Cremation</b>		24B. DATE <b>1-21-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1972</b>		25B. NAME OF REGISTRAR <b>John J. Duda</b>	
25C. FUNERAL DIRECTOR <b>John J. Duda</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00666

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William Lingard		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 17 Year 72 Hour 9:00 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 502 W. Fayette Street		3. DATE PRONOUNCED DEAD Month 1 Day 17 Year 72 Hour 9:00 P.M.	
6. SEX Male		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 7/12/1899		10. AGE (In years last birthday) 72	
11. BIRTHPLACE (State or foreign country) Tennessee		12. CITIZEN OF WHAT COUNTRY? USA	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.	
18. INFORMANT ADDRESS Cawood Funeral Home, Box 877, Middlesboro, Ky		15. MOTHER'S MAIDEN NAME unknown	
19. 412.4 I CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/20/72	
24C. NAME OF CEMETERY or CREMATORY Greer Cemetery		24D. LOCATION (City, town, or county) (State) Claborn County, Tenn.	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1972		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR Witzke, 1630 Edmondson Ave., Balto. Md.		25D. ADDRESS 21228	

35 00000

35 00000

STATE OF NEW YORK

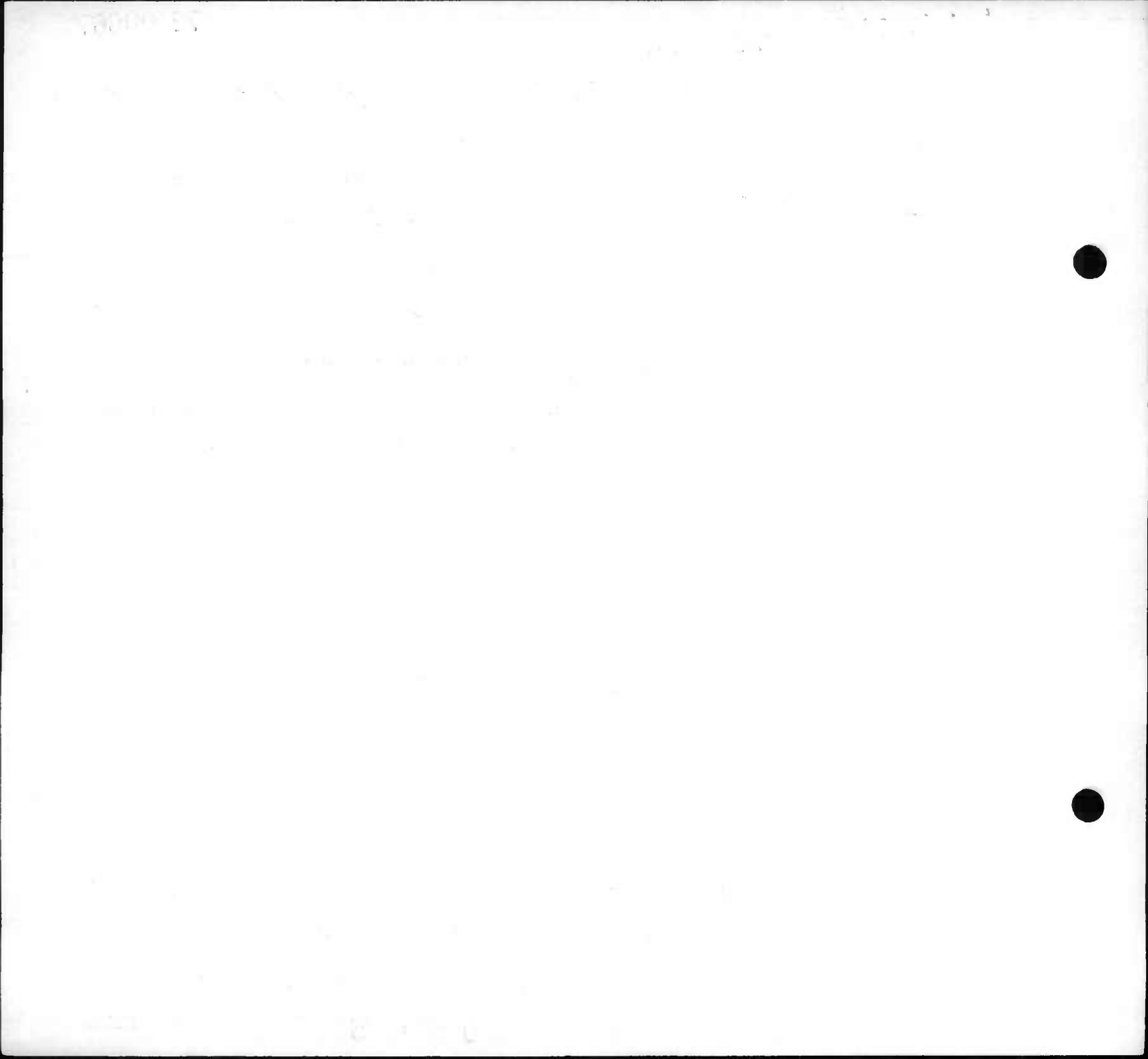
*[Faint, mostly illegible text, likely bleed-through from the reverse side of the page. The text appears to be organized into sections, possibly including a title, a body of text, and a signature block.]*



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

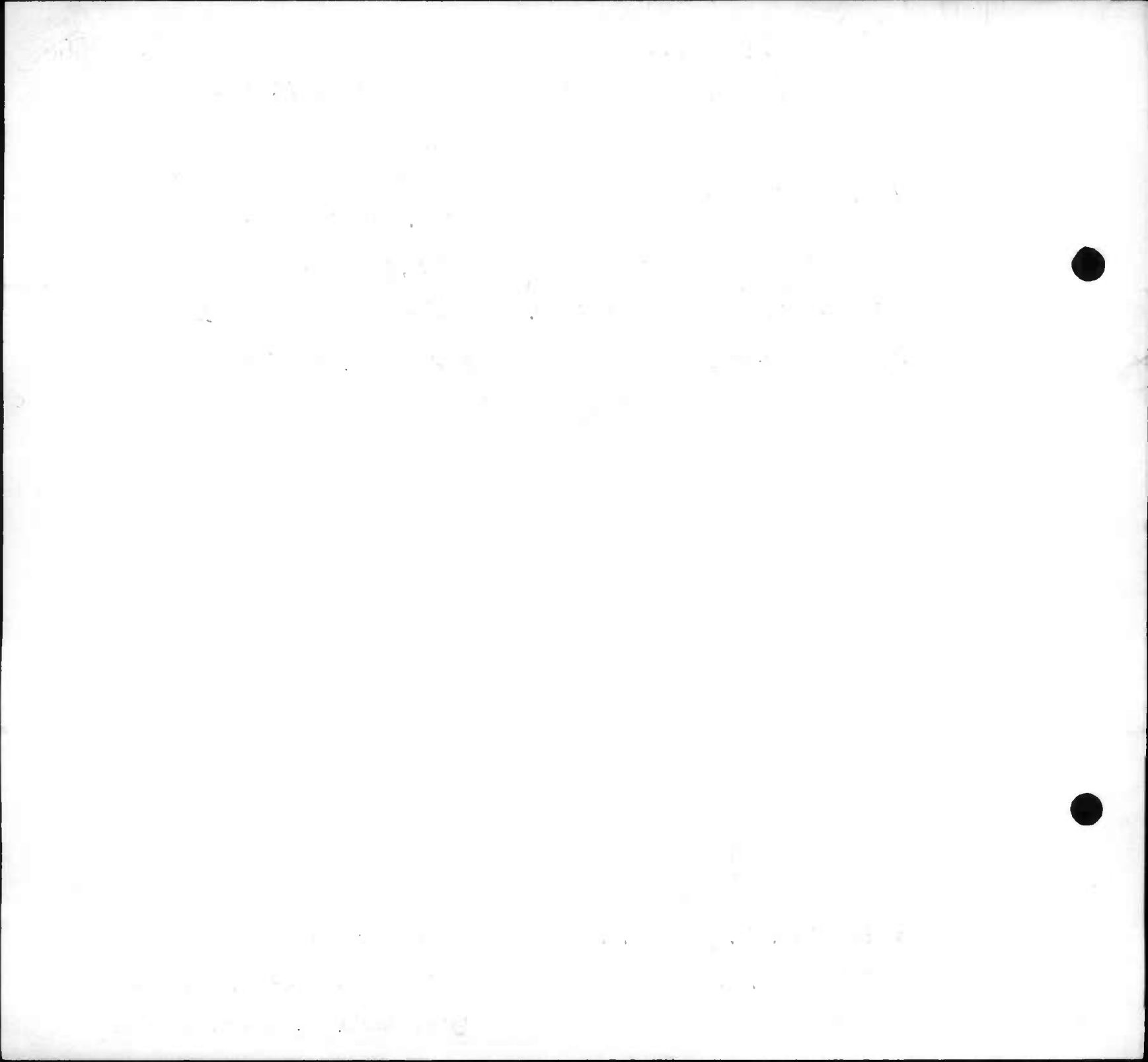
BALTIMORE CITY HEALTH DEPARTMENT		72 00667		72 00667	
BIRTH NO.		72 00667		REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Amos, Milton Edward</u>			2. DATE AND HOUR OF DEATH <u>1/18/72</u> <u>8<sup>30</sup></u> A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>UNIV. Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <u>MD</u> B. COUNTY <u>285-4</u>		
5. SEX <u>M</u> 6. RACE <u>W</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>5/1/00</u> 9. AGE (In years last birthday) <u>71</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>ret</u>			11. BIRTHPLACE (State or foreign country) <u>MD</u>		
13. FATHER'S NAME <u>HARRY D. Amos</u>			14. MOTHER'S MAIDEN NAME <u>NAOMI DAVIS</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO. <u>218-03-3891</u>		
17. INFORMANT <u>chant Milton Amos, Jr.</u>			ADDRESS <u>311 Nottingham Rd.</u>		
18. <u>162.1 I</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Metastatic Carcinoma of the lung</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		
20A. AUTOPSY? (Yes or No) <u>NO</u>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <u>1/15</u> 19 <u>72</u> to <u>1/18</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>1/17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>John R. Sattenfield MD</u>			23B. DATE SIGNED <u>1/18/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>John Sattenfield MD</u>			23D. ADDRESS <u>UNIV. Hospital</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/21/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Dulaney Valley</u>	
24D. LOCATION <u>Towson, Maryland</u>		24E. (City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1972</u>		25B. NAME OF REGISTRAR <u>John R. Sattenfield MD</u>		25C. FUNERAL DIRECTOR <u>Hitzke, 1630 Edmondson Avenue 21228</u>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

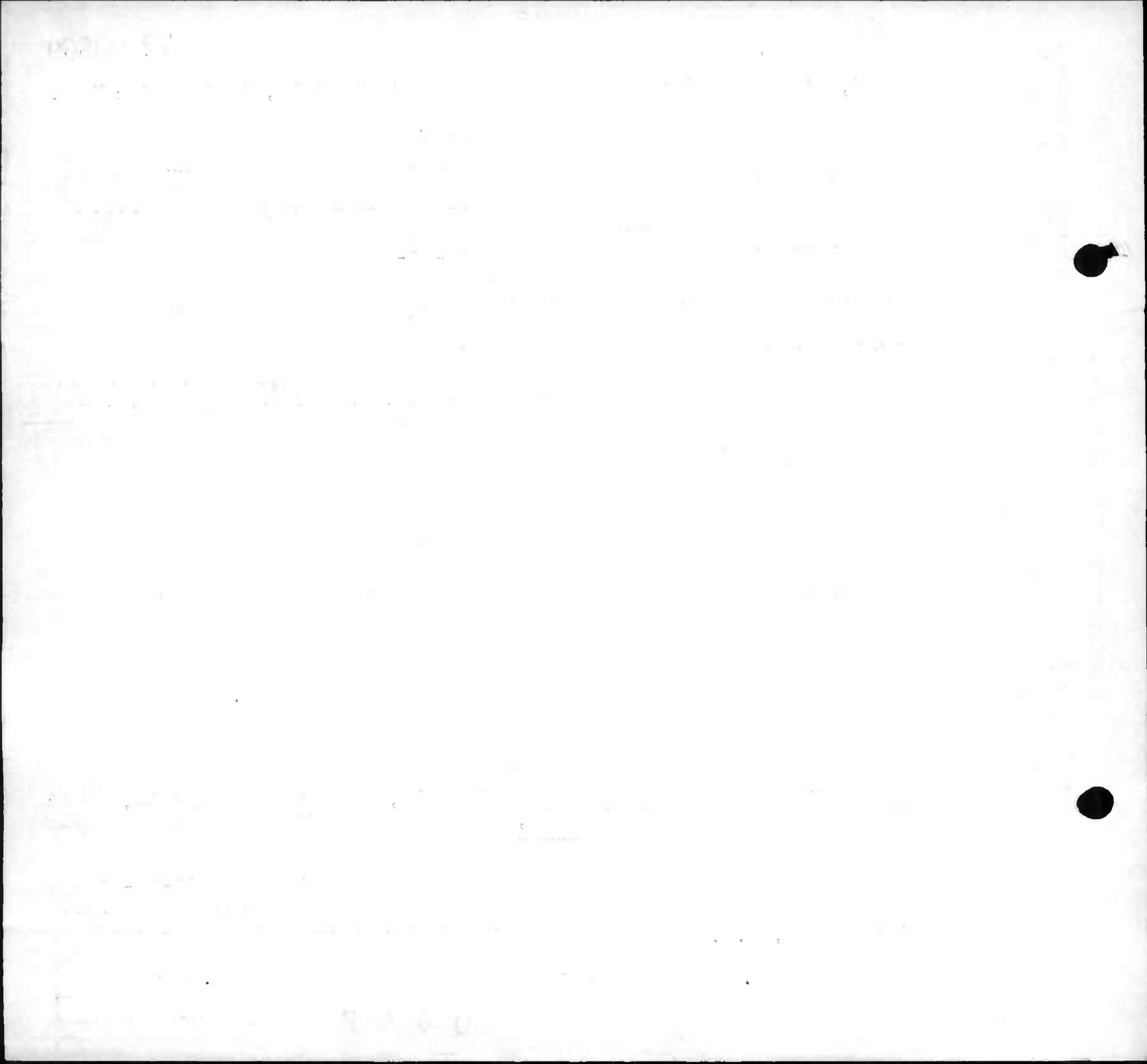
<p><b>J-525</b></p> <p>BIRTH NO. <b>72 00668</b></p>		<p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 00668</b></p>	
<p>1. NAME OF DECEASED (Type or Print) <b>Albert C Jenezon</b></p>			<p>2. DATE AND HOUR OF DEATH <b>January 17, 1972</b></p>		
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>218 W. Lorraine Avenue</b></p>			<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE <b>Maryland</b> B. COUNTY <b>1207</b></p> <p>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>218 W. Lorraine Avenue</b></p>		
<p>5. SEX <b>Male</b></p>	<p>6. RACE <b>White</b></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>August 15, 1894</b></p>	<p>9. AGE (In years last birthday) <b>77</b></p>	<p>10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician-retired</b></p>			<p>10B. KIND OF BUSINESS OR INDUSTRY <b>Gas &amp; Electric Co.</b></p>		<p>11. BIRTHPLACE (State or foreign country) <b>Holland</b></p>
<p>12. CITIZEN OF WHAT COUNTRY? <b>USA</b></p>			<p>13. FATHER'S NAME <b>Jacobus Jenezon</b></p>		
<p>14. MOTHER'S MAIDEN NAME <b>Johanna Sophia Kilian</b></p>			<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WW I</b></p>		
<p>16. SOCIAL SECURITY NO. <b>212-05-4804</b></p>			<p>17. INFORMANT <b>Family records</b></p>		
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Coronary Thrombosis</b></p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Cardiovascular Disease</b></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p>(C)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>II</p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>					
<p>19A. DATE OF OPERATION <b>0 none</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>		<p>20A. AUTOPSY? (Yes or No) <b>No</b></p>	
<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>		<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>			
<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>			
<p>21D. TIME OF INJURY (APPROX.)</p>		<p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>Feb. 27 1965</b> to <b>Jan. 17 1972</b> that (I) (we) last saw the deceased alive on <b>Dec. 14 1971</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>					
<p>23A. SIGNATURE <b>L. Myrton Gaines, Jr. M.D.</b></p>			<p>23B. DATE SIGNED <b>Jan. 19, 1972</b></p>		
<p>23C. PHYSICIAN'S NAME (Type) <b>Myrton Gaines, Jr. M.D.</b></p>			<p>23D. ADDRESS <b>7800 York Road, Towson, Maryland</b></p>		
<p>24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>Jan. 20, 1972</b></p>		<p>24C. NAME OF CEMETERY OR CREMATORY <b>Dulaney Valley Memorial</b></p>	
<p>24D. LOCATION (City, town, or county) <b>Cockeysville, Maryland</b></p>		<p>24E. (State)</p>			
<p>25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Robert E. Fisher, R.D. 2</b></p>		<p>25C. FUNERAL DIRECTOR <b>John Buhns Sons, Towson, Maryland</b></p>	
<p>25D. ADDRESS</p>		<p>25E. (City, town, or county)</p>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

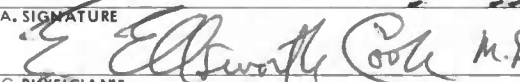
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00669</u>	
0-500		72 00669		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>CHANEY, WILLIAM EDGAR</u>		2. DATE AND HOUR OF DEATH <u>JANUARY 19, 1972</u>   <u>12:02 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>ST AGNES HOSPITAL</u> <u>40</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2544</u> C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>708 PONTIAC AVENUE</u> <u>21225</u>			
5. SEX <u>MALE</u>	6. RACE <u>CAUCASIAN</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>08-03-09</u>	9. AGE (in years last birthday) <u>62</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FIREFIGHTER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>FIRE DEPARTMENT</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>AUGUST CHANEY</u>			
14. MOTHER'S MAIDEN NAME <u>(</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>213 05 2384</u>		17. INFORMANT <u>RECORD'S BALTIMORE MD 21229</u> <u>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>412.19 250.9</u> <u>CVA</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hypertensive heart dis</u> <u>10 yrs</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Emphysema Diabetes</u> <u>mob</u>			
(C) _____					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>XIX</u> (this hospital) attended the deceased from <u>JANUARY 18, 1972</u> to <u>JANUARY 19, 1972</u> that <u>XIX</u> (we) last saw the deceased alive on <u>JANUARY 19, 1972</u> and that in <u>(XIX)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) <u>(XIX)</u> view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>01-19-72</u>		23C. PHYSICIAN'S NAME (Type) <u>JOSE APTER, M.D.</u>	
23D. ADDRESS <u>BALTIMORE MD 21229</u> <u>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/22/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Glen Haven Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Glen Burnie Md. 21061</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>	
ADDRESS <u>237 Patapsco Ave</u>					





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00670</u>
<b>BIRTH NO.</b> <u>M-435</u> <b>72 00670</b>		<b>CERTIFICATE OF DEATH</b>		
<b>1. NAME OF DECEASED</b> (Type or Print) <b>CHARLES CURTIS MOULTON</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>1-18-72</b> <b>11:00</b> <b>P</b> <b>M.</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>2324 N. Charles Street</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) <b>A. STATE</b> <b>Maryland</b> <b>B. COUNTY</b> <b>Baltimore City</b> <b>1206</b> <b>C. CITY OR TOWN</b> <b>Baltimore</b> <b>D. INSIDE CITY LIMITS?</b> <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>2324 N. Charles Street</b>		
<b>5. SEX</b> <b>Male</b>	<b>6. RACE</b> <b>White</b>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>11/28/1903</b>	<b>9. AGE</b> (In years last birthday) <b>67</b> <b>If Under 1 Yr. Months Days</b> <b>If Under 24 Hrs. Hours Min.</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Electrical</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Construction</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Havre de Grace</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>13. FATHER'S NAME</b> <b>James Columbus Moulton</b>		
<b>14. MOTHER'S MAIDEN NAME</b> <b>Laura Bell Ruth</b>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b> <b>No</b>		
<b>16. SOCIAL SECURITY NO.</b> <b>217 03 0974 A</b>		<b>17. INFORMANT</b> <b>ADDRESS</b> <b>Mrs. Doris B. Moulton, Baltimore, Md. 2324 N. Charles St</b>		
<b>18. CAUSE OF DEATH</b> <b>I</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  <b>8 years</b>  <b>several years</b>
<b>19A. DATE OF OPERATION</b> <b>0</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)
<b>21A. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (notify medical examiner)		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>Feb. 4, 1963</b> <b>to Jan. 18, 1972</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>Jan 7, 1972</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.</b>				
<b>23A. SIGNATURE</b> 			<b>23B. DATE SIGNED</b> <b>1-18-72</b>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>E. ELLSWORTH COOK M.D.</b>			<b>23D. ADDRESS</b> <b>2431 Maryland Ave. Balto Md. 21218</b>	
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>1/20/1972</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Wesleyan Chapel Cemetery</b>
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Paradise &amp; Near Chapel Roads Havre de Grace Md.</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 21 1972</b>		
<b>25B. NAME OF REGISTRAR</b> <b>Charles E. ...</b>		<b>25C. FUNERAL DIRECTOR</b> <b>ADDRESS</b> <b>... Havre de Grace, Md.</b>		

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

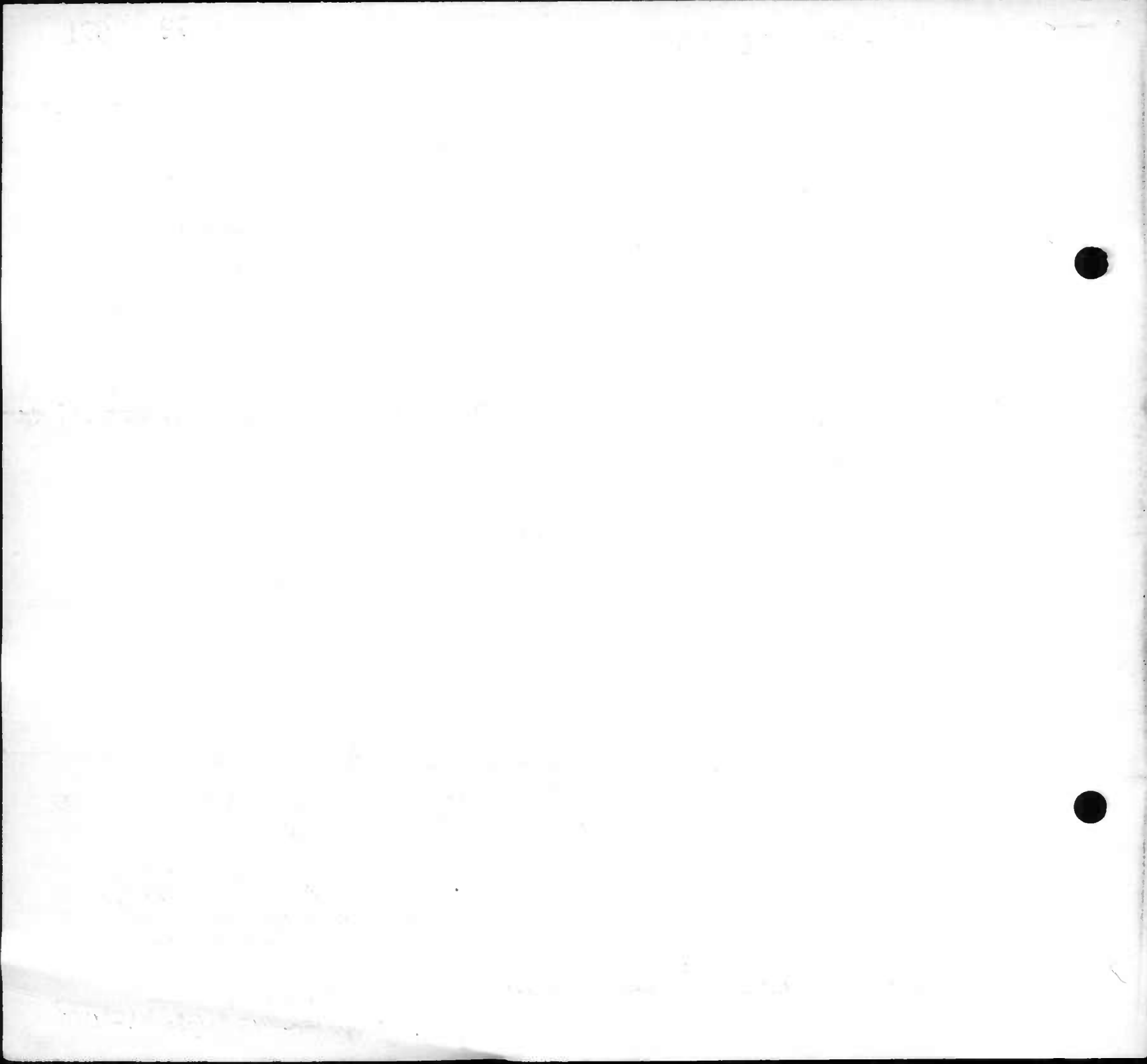
100-100000

100-100000

100-100000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

D-250		72 00671		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00671	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>DEGEN, JULIUS</b>				2. DATE AND HOUR OF DEATH <b>JAN 15TH 1972</b> <b>4:45 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE UNION MEMORIAL HOSPITAL</b> <b>44</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2702</b>			
				C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>3021 BEVERLY ROAD, BALTIMORE MD 21214</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11-23-94</b>	9. AGE (In years last birthday) <b>77</b>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Real Estate</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>GERMANY</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Heinrich Degen</b>				14. MOTHER'S MAIDEN NAME <b>Elisabetha Willrich</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>215-10-4893</b>		17. INFORMANT ADDRESS <b>Martilda C. Degen - 3021 Beverly Rd</b>	
18. <b>590.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Acute MI.</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Old History of MI.</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>History of pyelonephritis.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/15</b> 19 <b>72</b> to <b>1/15</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/15</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Jeremi Fan-claf</b>				23B. DATE SIGNED <b>1/15/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>ZEN-CHI FAN-CHIANG</b>				23D. ADDRESS <b>33RD AND CALVERT STS, BALTIMORE MD 21218</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-19-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Moreland Memorial</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1972</b>		25B. NAME OF REGISTRAR <b>Robert J. J. J.</b>		25C. FUNERAL DIRECTOR <b>John F. Miller</b>		ADDRESS <b>Inc-6415 Belair Rd. - 21206</b>	



DECLINED BY MEDICAL EXAMINER'S OFFICE AS NOT AN MEDICAL  
FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00672	
C-652 72 00672				72 672	
BIRTH NO.				REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>DANIEL E. CHRONISTER</u>			2. DATE AND HOUR OF DEATH <u>JAN. 17, 1972</u> <u>1:35 P.</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u>			A. STATE <u>PENNSYLVANIA</u>		
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>BALTIMORE, MD 21205</u>			B. COUNTY <u>HANOVER</u> <u>V35</u>		
			C. CITY OR TOWN <u>HANOVER</u>		
			D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER <u>122 LOCUST ST</u>		
5. SEX <u>M</u>	6. RACE <u>CAUC.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/10/71</u>	9. AGE (in years lost birthday) <u>16</u> <u>YES</u>	10. If Under 1 Yr. Months Days <u>10</u> <u>7</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			11. BIRTHPLACE (State or foreign country) <u>PENNA.</u>		
10B. KIND OF BUSINESS OR INDUSTRY <u>---</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		
13. FATHER'S NAME <u>ROBERT CHARLES CHRONISTER</u>			14. MOTHER'S MAIDEN NAME <u>ROSELLA PITTMAN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>---</u>		
17. INFORMANT <u>Robert C. Chronister</u>			ADDRESS <u>HANOVER, PA.</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>750.21</u> <u>Cerebral edema + CNS hypoxia</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Hyperthermia + acidosis during surgery</u> <u>3 days</u>		
			(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Tracheo-esophageal Fistula REPAIR</u> <u>10 months</u>		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>IMPERFORATE ANUS</u>					
19A. DATE OF OPERATION <u>3/11/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>FISTULA REPAIR</u>		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/5</u> 19 <u>72</u> to <u>1/17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Alan I. Fields</u>			23B. DATE SIGNED <u>1/17/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>ALAN I. FIELDS</u>			23D. ADDRESS <u>601 N. BROADWAY, BALD MD</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-20-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>	
24D. LOCATION <u>HANOVER YORK CO PA.</u>		24E. NAME OF REGISTRAR <u>John E. Fields</u>		24F. FUNERAL DIRECTOR <u>Chapman Home</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1972</u>		25B. NAME OF REGISTRAR <u>John E. Fields</u>		25C. FUNERAL DIRECTOR <u>Chapman Home</u>	

UNITED STATES DEPARTMENT OF AGRICULTURE  
BUREAU OF PLANT INDUSTRY  
WASHINGTON, D. C.

## CERTIFICATE OF DEATH

REG. NO.

72 00673

BIRTH NO.

1. NAME OF DECEASED

(Type or Print)

O'SULLIVAN, Anna

2. DATE AND HOUR OF DEATH

1/16/72

2640 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE  
Maryland

B. COUNTY

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

5017 Wright Avenue

21205

5. SEX

Female

6. RACE

Caucasian

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

10-21-13

9. AGE (In years  
last birthday)

58

If Under 1 Yr.

Months

Days

Hours

Min.

If Under 24 Hrs.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Home Maker

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Philip Thibert

14. MOTHER'S MAIDEN NAME

Margaret J. Reinsfelder

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)

No

16. SOCIAL  
SECURITY NO.

214-14-8178

17. INFORMANT

4940 Eastern Avenue

BCH: Records Baltimore, Maryland 21224

18. 425X I

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

CAPAD RESPIRATORY FAILURE

5 min

(B)

DUE TO, OR AS A CONSEQUENCE OF:

CONGESTIVE HEART FAILURE

2 min

(C)

DUE TO, OR AS A CONSEQUENCE OF:

CAPAD MYOCLONUS

6 min

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

PNEUMOTHORAX, BRONCHOPNEUMONIA

EFFUSIONS  
22 min

MEDICAL CERTIFICATION

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 8 Jan 1972 to 16 Jan 1972,  
that (I) (we) last saw the deceased alive on 1/16 1972 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

23A. SIGNATURE

Stephen Nightingale M.D.

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

1/16/72

23C. PHYSICIAN'S  
NAME (Type)

Stephen Nightingale, M.D.

DEGREE

23D. ADDRESS

Baltimore City Hospitals  
4940 Eastern Avenue Baltimore, Maryland 2122424A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-20-72

24C. NAME OF CEMETERY or CREMATORY

Holy Redeemer Cemetery

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1972

25B. NAME OF REGISTRAR

Robert E. Taylor, M.D.

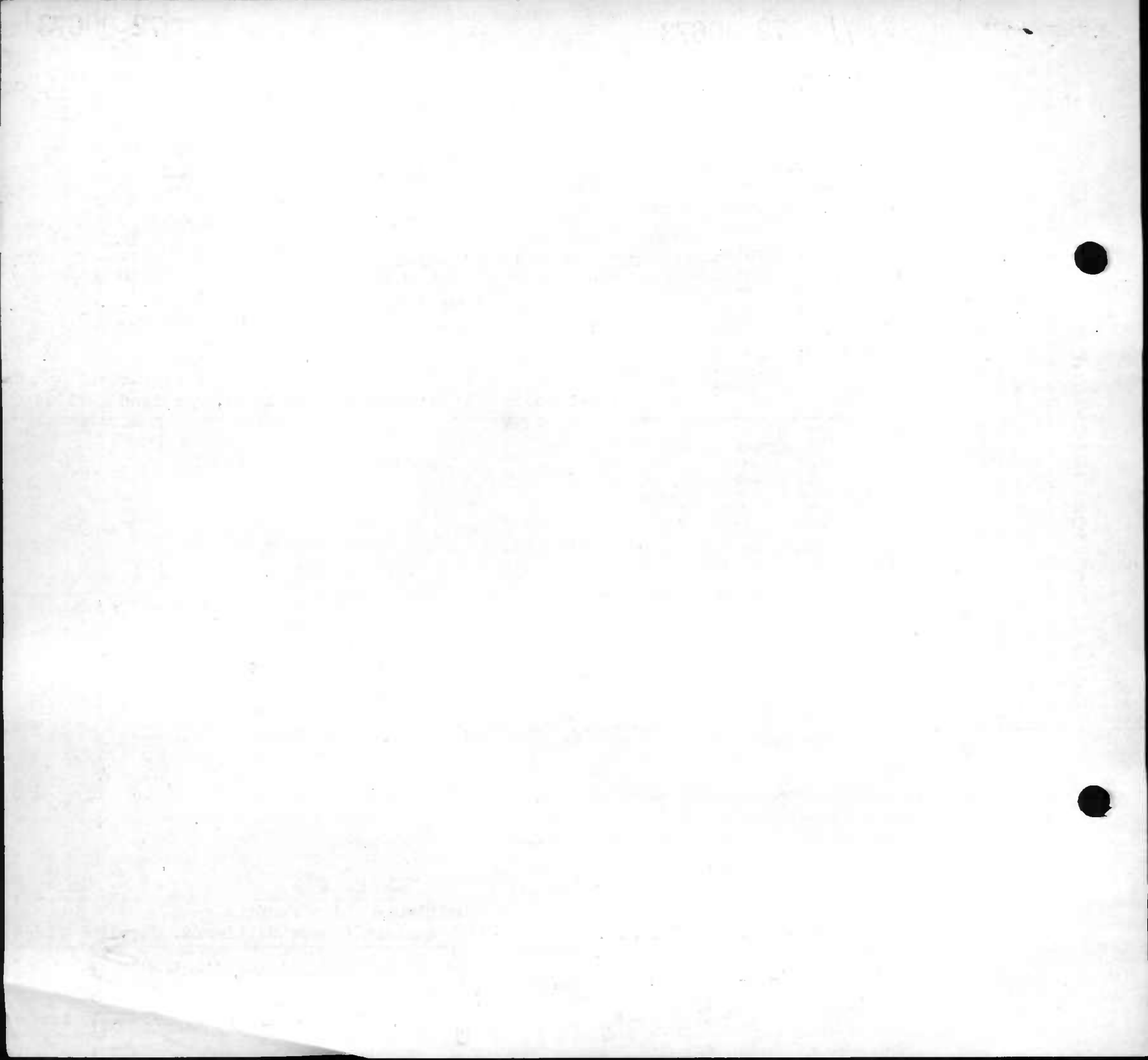
25C. FUNERAL DIRECTOR

John C. Miffler Inc-6415 Belair Road

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

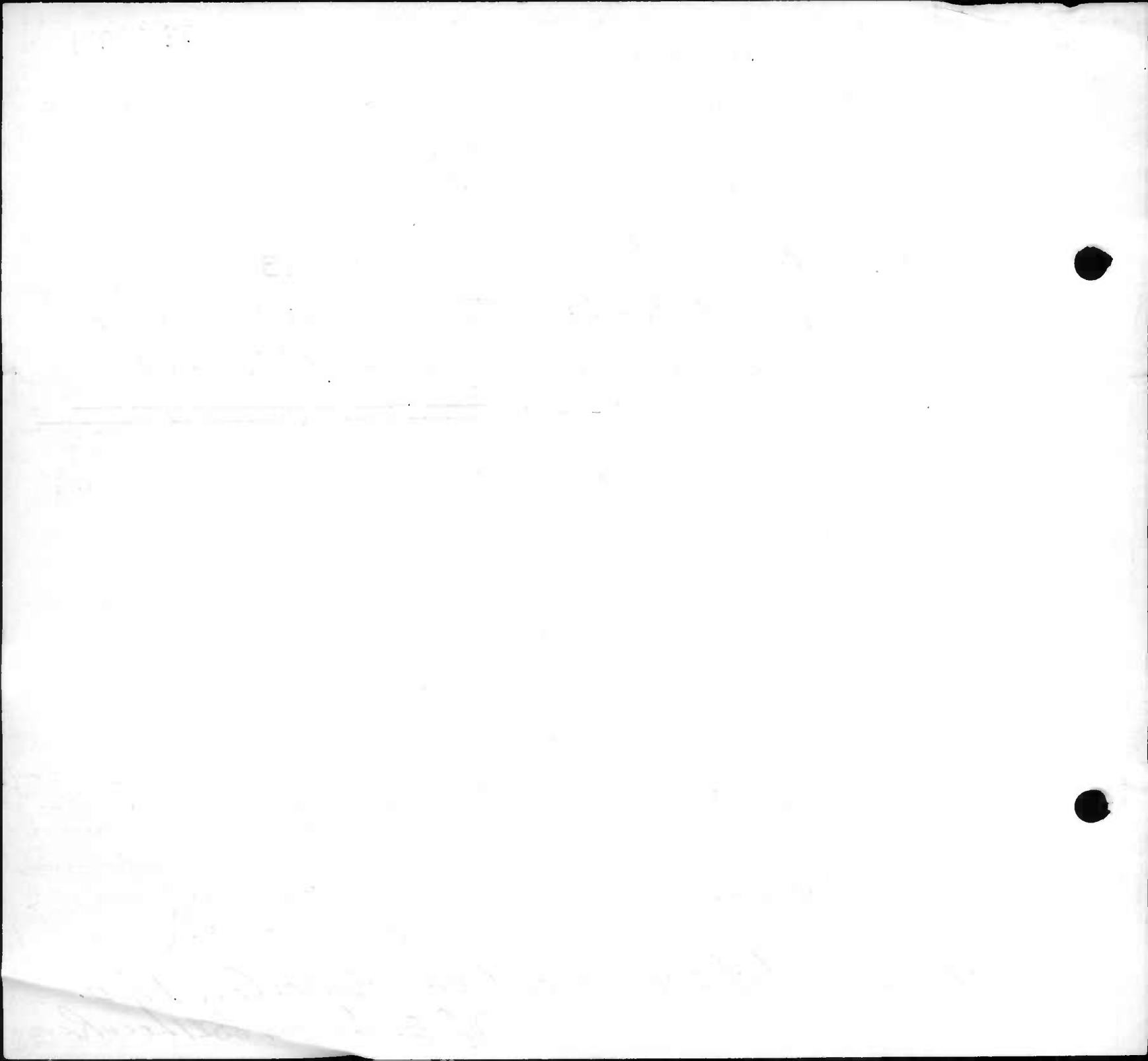




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

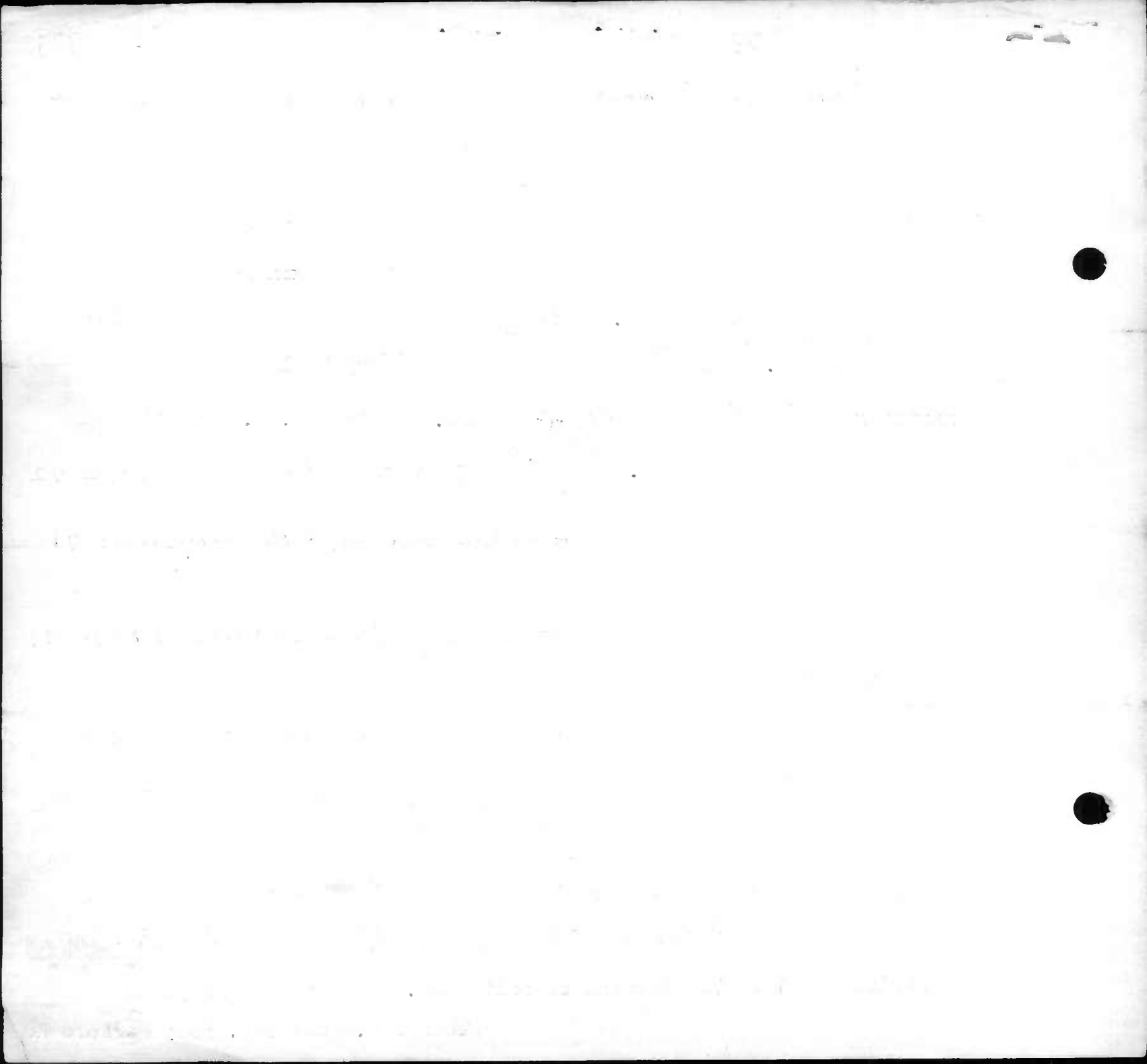
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 00674	
S-522		72 00674					
1. NAME OF DECEASED (Type or Print) <u>Simcox, John M.</u>				2. DATE AND HOUR OF DEATH <u>18 Jan 1972 12:50 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>University Hospital</u> <u>38</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>8322 Old Harford Rd.</u>			
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5 Aug 1938</u>	9. AGE (In years lost birthday) <u>33</u>	10. Under 1 Yr. Months: Days: Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Fireline, Inc.</u>		11. BIRTHPLACE (State or foreign country) <u>PENNSYLVANIA</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>				13. FATHER'S NAME <u>John H. Simcox</u>			
14. MOTHER'S MAIDEN NAME <u>Lovdy MICHAEL</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u>			
16. SOCIAL SECURITY NO. <u>216-34-7825</u>				17. INFORMANT <u>Deceased MICHAEL</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Chronic Myelogenous Leukemia</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (At stating the UNDERLYING CONDITION lost.) <u>None</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 mos.</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>None</u>							
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>JANUARY 10 19 72</u> to <u>JANUARY 18 19 72</u> that (I) (we) last saw the deceased alive on <u>JANUARY 18 19 72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Robert Hartmann, MD</u>				23B. DATE SIGNED <u>18 January 1972</u>		23C. PHYSICIAN'S NAME (Type) <u>Robert Hartmann, MD</u>	
23D. ADDRESS <u>University Hospital</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>			
24B. DATE <u>1/20/72</u>				24C. NAME OF CEMETERY OR CREMATORY <u>PARKWOOD CEM.</u>		24D. LOCATION (City, town, or county) (State) <u>BALTO. Co., MD.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1972</u>				25B. NAME OF REGISTRAR <u>Robert E. Gable, MD.</u>		25C. FUNERAL DIRECTOR <u>Wm. E. Johnson 8521 Loch Raven</u>	



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
S-530		72 00675		72 00675	
1. NAME OF DECEASED (Type or Print) <u>Sinnott, James</u>			2. DATE AND HOUR OF DEATH <u>1-17-72</u> <u>12</u> <u>a</u> <u>M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Mon Tebeles 2201 Argonne Dr. S.H.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balt. City</u> <u>4929 Schaub Ave. Balt. 21206</u>		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Mon Tebeles 2201 Argonne Dr. S.H.</u>			C. CITY OR TOWN <u>Balt.</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>4929 Schaub 2653</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-28-22</u>	9. AGE (In years last birthday) <u>49</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Superior Village</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Balto. Police</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>Charles E. Sinnott</u>		14. MOTHER'S MAIDEN NAME <u>Mary Touhan</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes WW II</u>		16. SOCIAL SECURITY NO. <u>217-1600</u>		17. INFORMANT <u>Mrs. Patricia H. M. Sinnott</u> Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Bilateral Pneumonia</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1-12-72</u>		
(This does not mean the mode of dying, i.e., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			19. MEDICAL CAUSE OF DEATH, OR AS A CONSEQUENCE OF: <u>Cranio-cerebral Injuries</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <u>Dom. Tra. Cranio-cerebral Hemorrhage</u> <u>10-18-71</u>		
			(C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>Bleeding Duodenal Ulcer</u>			<u>10-10-71</u>		
19A. DATE OF OPERATION <u>06 MAR. 71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bleeding Gastrostomy</u>		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Home</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>4929 Schaub Ave. Balt.</u>	
21D. TIME OF INJURY (Approx.) <u>10-18-71 8AM</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Fell Down Stairs</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>12-22</u> 19 <u>71</u> to <u>1-17</u> 19 <u>72</u> that (I) (we) lost saw the deceased alive on <u>1-16</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>George F. Ritchie M.D.</u>			23B. DATE SIGNED <u>1-17-72</u>		23C. PHYSICIAN'S NAME (Type) <u>George F. Ritchie M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>1/20/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cem.</u>
24D. LOCATION <u>Baltimore Maryland</u>			25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1972</u>		
25B. NAME OF REGISTRAR <u>Leonard J. Ruck Inc.</u>			25C. FUNERAL DIRECTOR, ADDRESS <u>5305 Harford Rd</u>		



M-220

72 00676

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00676

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

John J. Masucci

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour  
1 19 72 M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)

38 University Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour  
1 19 72 6:45 a. M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE DEL. B. COUNTY V07

6. SEX  
male

7. RACE  
White

8. MARRIED ☐ NEVER MARRIED ☐  
WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN  
WILMINGTON

D. INSIDE CITY LIMITS?  
YES ☒ NO ☐

9. DATE OF BIRTH

4/7/1904

10. AGE (In years last birthday)  
67

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

416 Delmore Pl.

11. BIRTHPLACE (State or foreign country)

Delaware

12. CITIZEN OF WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Antonio Masucci

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Fire Chief

14B. KIND OF BUSINESS OR INDUSTRY

Delaware Park

15. MOTHER'S MAIDEN NAME

Louise League

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO.

18. INFORMANT

ADDRESS

19. E 812.0

CAUSE OF DEATH

Multiple injuries

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(crushed chest)

(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.

(B) DUE TO, OR AS A CONSEQUENCE OF:

(C) DUE TO, OR AS A CONSEQUENCE OF:

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS UNDERLYING ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  
Highway

22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

J.F.K. Hwy 060, South on 95

22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  
1 19 72 5:38

22E. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒

22F. HOW DID INJURY OCCUR?

Subject driver in car/truck collision

23.

I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

Ronald N. Kornblum, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☒

ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1/19/72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-21-72

24C. NAME OF CEMETERY or CREMATORY

Cathedral

24D. LOCATION (City, town, or county) (State)

Wilmington Del.

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1972

25B. NAME OF REGISTRAR

Robert E. Talley, M.D.

25C. FUNERAL DIRECTOR

Mc Cully Funeral Homes - Baltimore, Md.

25 10076

25 10076

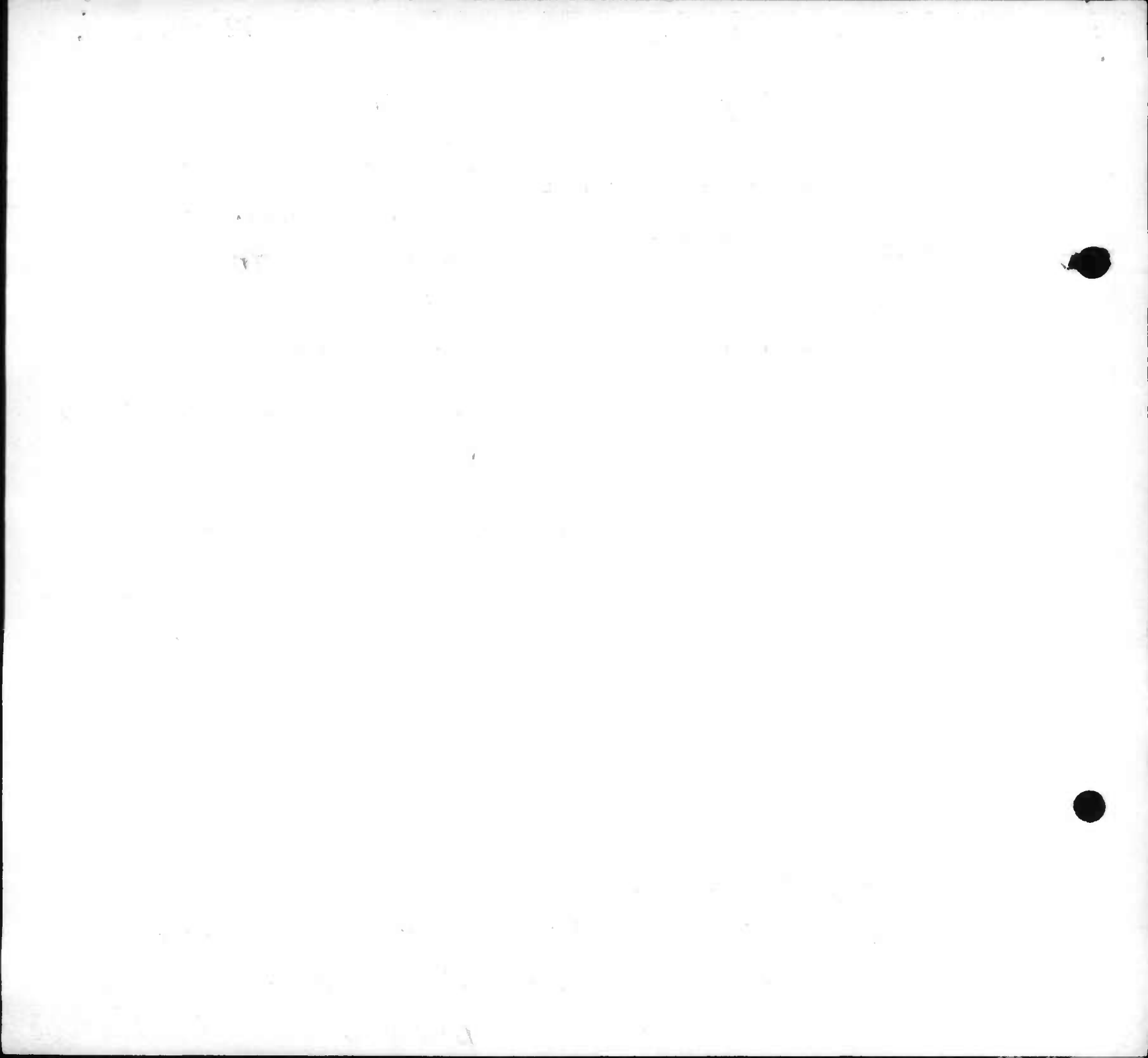
Belmont  
R. L. Chief  
U.S.A. District Attorney  
Belmont Post Office Building  
New York

Belmont  
R. L. Chief  
U.S.A. District Attorney  
Belmont Post Office Building  
New York

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-452		72 00677		BALTIMORE CITY HEALTH DEPARTMENT		72 00677	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <i>Williams, Julius</i>				2. DATE AND HOUR OF DEATH <i>1/17 2PM 1-17-72</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>807</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>33 THE JOHNS HOPKINS HOSPITAL</i>				C. CITY OR TOWN <i>BALTIMORE</i>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <i>1708 E. PRESTON ST.</i>							
5. SEX <i>MALE</i>	6. RACE <i>NEGRO</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-22-00</i>	9. AGE (In years last birthday) <i>70</i>	If Under 1 Yr. Months Days	If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>—</i>		11. BIRTHPLACE (State or foreign country) <i>N. Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME <i>JOSEPH WILLIAMS</i>				14. MOTHER'S MAIDEN NAME <i>LUCILLE BATON</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Etta Williams - 1708 E. Preston St.</i>			
18. <i>412.31</i> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <i>Cardiorespiratory Arrest</i> DUE TO, OR AS A CONSEQUENCE OF: (B) <i>Severe AS &amp; HTN, Uremia, CHF</i> DUE TO, OR AS A CONSEQUENCE OF: (C) <i>—</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>YES</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <i>Dec 1</i> 19 <i>71</i> to <i>January 17</i> 19 <i>72</i> that (1) (we) last saw the deceased alive on <i>1/17</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>J. Harold Helderman, MD</i>				23B. DATE SIGNED <i>1/17/72</i>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <i>J. HAROLD HELDERMAN, MD</i>				23D. ADDRESS <i>Johns Hopkins Hosp</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1-21-72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Mt. Auburn Cem.</i>		24D. LOCATION (City, town, or county) (State) <i>Westport, Md.</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 21 1972</i>		25B. NAME OF REGISTRAR <i>Robert E. ...</i>		25C. FUNERAL DIRECTOR <i>Malton &amp; Elcton</i>		ADDRESS <i>1129 N. Carolina St.</i>	

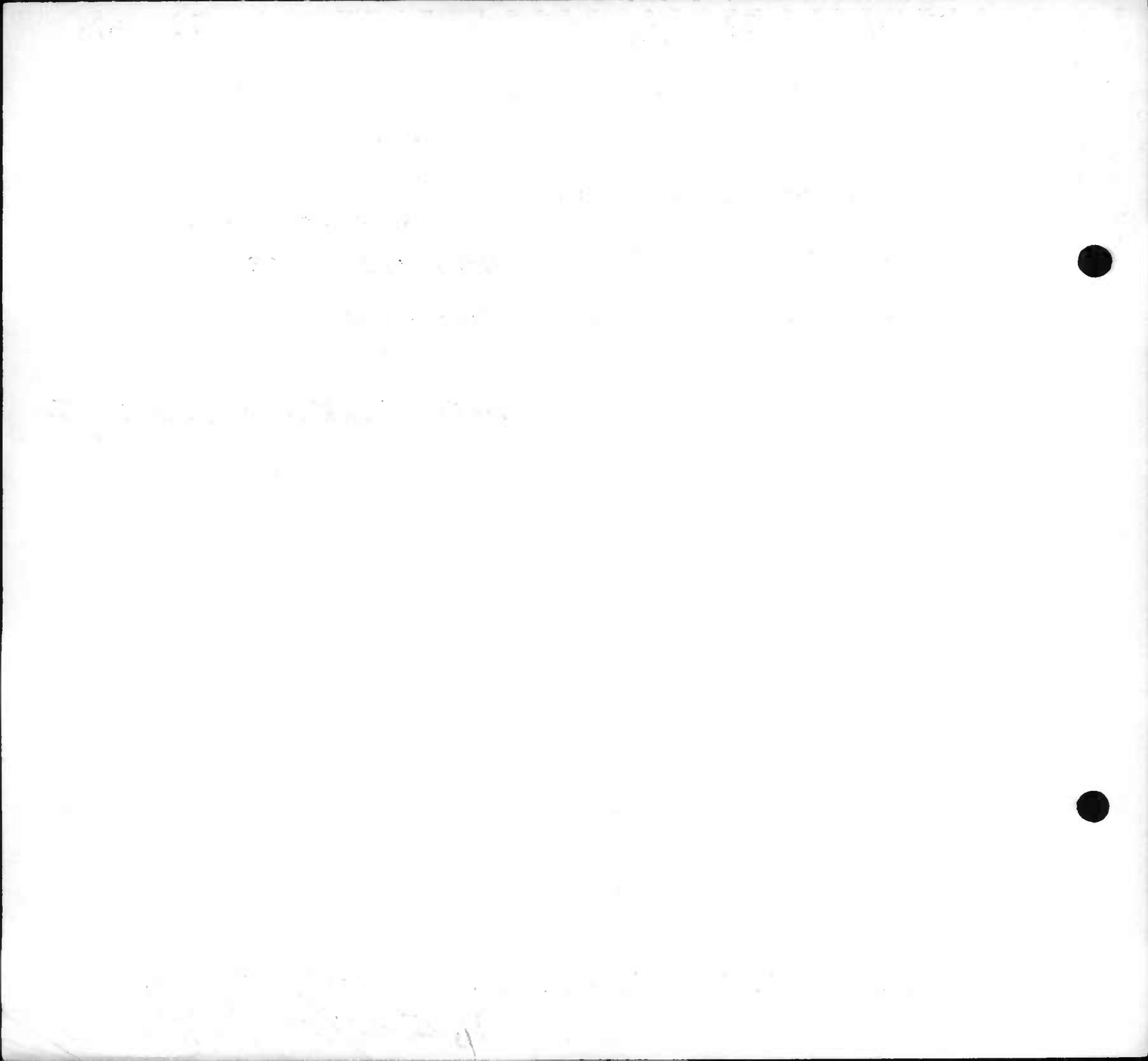




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT 72 00678 CERTIFICATE OF DEATH				REG. NO. 72 00678	
BIRTH NO. 7-652		1. NAME OF DECEASED (Type or Print) <b>WILLIAM FRANKLIN</b>		2. DATE AND HOUR OF DEATH <b>8:00 AM 1/18/72</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>33 The Johns Hopkins Hospital</b>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>604</b>		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 The Johns Hopkins Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>419 N. Washington Street</b>		
5. SEX <b>Male</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4-19-1913</b>	9. AGE (In years last birthday) <b>58</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lumber</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>S. Carolina</b>	
13. FATHER'S NAME <b>William Franklin</b>			14. MOTHER'S MAIDEN NAME <b>Lula Elgin</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MATTIE FRANKLIN 419 N. Washington</b>	
18. <b>1/62-1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Cardiorespiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Lung ca &amp; metastases to the brain</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec. 19 1972</b> to <b>Jan 18 1972</b> that (I) (we) last saw the deceased alive on <b>Jan 18 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Martha L. Kopper, MD</b>			23B. DATE SIGNED <b>1/18/72</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>
23C. PHYSICIAN'S NAME (Type) <b>MARTHA L. KOPPER</b>			23D. ADDRESS <b>Johns Hopkins Hospital</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-22-72</b>		24C. NAME of CEMETERY or CREMATORY <b>MT. AUBURN CEM.</b>	
24D. LOCATION (City, town, or county) (State) <b>Westport, Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1972</b>			
25B. NAME OF REGISTRAR <b>Valerie E. [unclear]</b>		25C. FUNERAL DIRECTOR <b>Milton B. Edickson 1129 N. CAROLINE</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

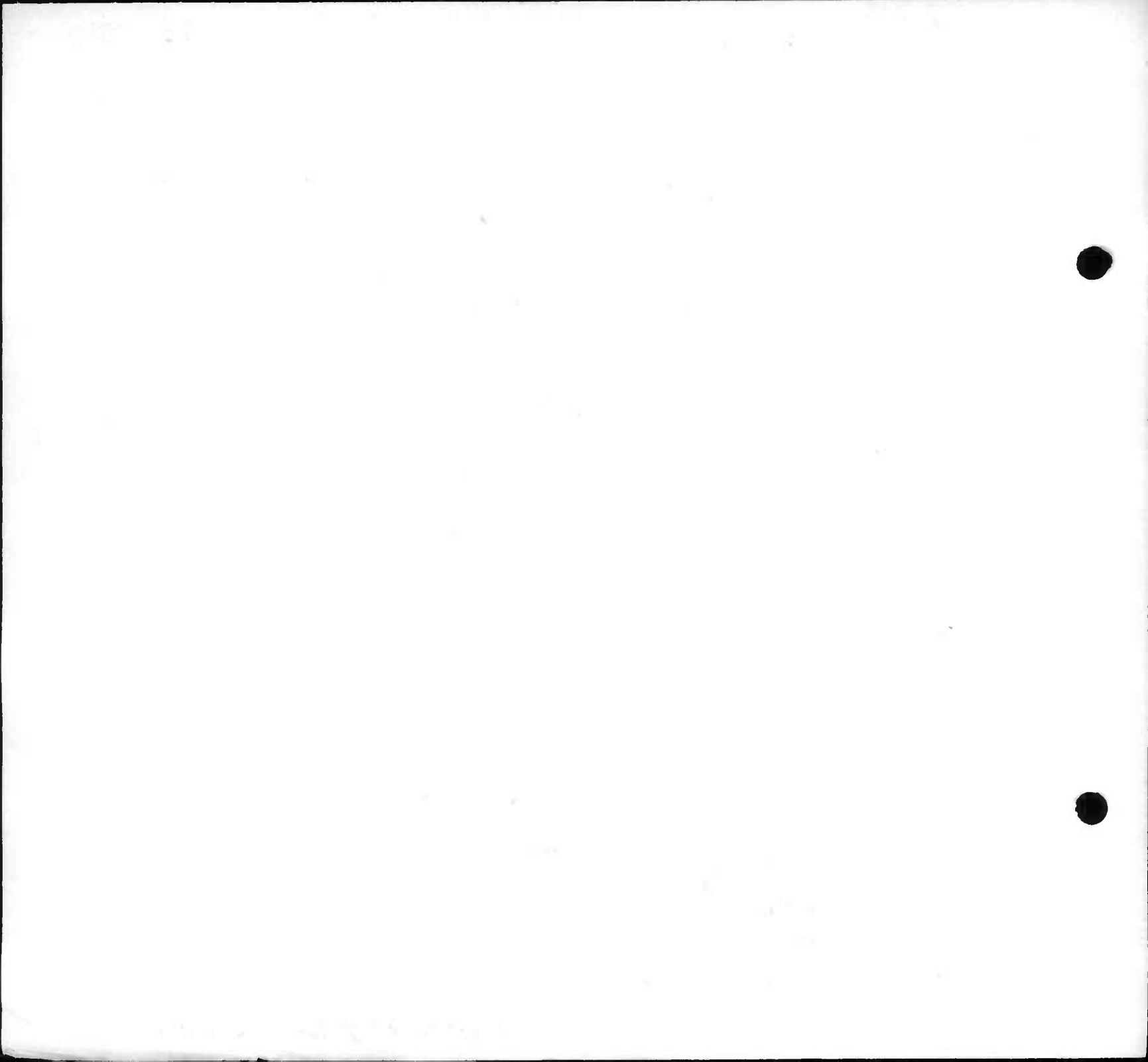
<p><b>B-200</b> <span style="float: right;">72 00679</span></p> <p style="text-align: center;"><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="text-align: center;"><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <span style="float: right;">72 00679</span></p>	
<p><b>BIRTH NO.</b></p> <p>1. NAME OF DECEASED (Type or Print) <u>RICE, ESSIE</u></p>		<p>2. DATE AND HOUR OF DEATH <u>January 20, 1972</u> <u>12:25 P.M.</u></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>91 MONTBELLO STATE HOSPITAL</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>908</u></p> <p>C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>910 BELAPARTE AVE.</u> <u>21218</u></p>	
<p>5. SEX <u>F</u></p>	<p>6. RACE <u>B</u></p>	<p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>4-1-1904</u></p>
<p>9. AGE (In years last birthday) <u>67</u></p>		<p>If Under 1 Yr. Months: Days: Hours: Min.</p>	<p>If Under 24 Hrs. Hours: Min.</p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <u>At Home</u></p>	
<p>11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u></p>		<p>12. CITIZEN OF WHAT COUNTRY? <u>United States</u></p>	
<p>13. FATHER'S NAME <u>Squire Peace</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>MINNIE BELL</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>		<p>16. SOCIAL SECURITY NO. <u>226-12-9730</u></p>	<p>17. INFORMANT <u>PATIENT'S CHART</u></p>
<p>18. <u>412.31</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Cardio-Respiratory Failure</u></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Few minutes</u></p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last.</p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonia + urinary Tract Infection</u> <u>9 days.</u></p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <u>II</u> <u>narrowing of right carotid Artery</u></p>		<p>(C) <u>Cardio-vascular Accident</u> <u>2 years</u></p>	
<p>19A. DATE OF OPERATION <u>0</u></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No) <input type="checkbox"/></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examined) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <u>5-12-1971</u> to <u>1-20-1972</u> that (I) (we) last saw the deceased alive on <u>1-20-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <u>Hanson S.H. Chen</u> M.D. DEGREE</p>		<p>23B. DATE SIGNED <u>1-20-72</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>HANSON S.H. CHEN</u> M.D. DEGREE</p>		<p>23D. ADDRESS <u>Montebello State Hospital, 2201 Argonne St., Baltimore Md. 21218</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Common</u></p>		<p>24B. DATE <u>1/21/72</u></p>	
<p>24C. NAME OF CEMETERY OR CREMATORY <u>Family Plot</u></p>		<p>24D. LOCATION (City, town, or county) (State) <u>Kennedee VA.</u></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1972</u></p>		<p>25B. NAME OF REGISTRAR <u>S. P. Taylor M.D.</u></p>	
<p>25C. FUNERAL DIRECTOR <u>Kennedee VA</u></p>		<p>ADDRESS <u>PER - M. D. HAYES</u></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.	
72 00680		72 00680			
1. NAME OF DECEASED (Type or Print) <u>Holmes, Aston S.</u>		2. DATE AND HOUR OF DEATH <u>1-17-72</u> <u>8:10 P</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE _____ B. COUNTY _____			
FULL NAME OF HOSPITAL OR INSTITUTION <u>LUTHERAN HOSPITAL OF MD</u> <u>46</u>		C. CITY OR TOWN <u>BAITIMORE MD</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>1302 McCulloch ST</u>			
5. SEX <u>MALE</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-5-97</u>	9. AGE (in years last birthday) <u>75</u>	10. Under 1 Yr. Months: _____ Days: _____ 11. Under 24 Hrs. Hours: _____ Min. _____
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>U.S. MARINE</u>		11. BIRTHPLACE (State or foreign country) <u>Jamaica B.W.I.</u>	
13. FATHER'S NAME <u>Unknown</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-14-6256</u>		17. INFORMANT <u>DAUGHTER</u>	
		ADDRESS <u>SARAH DEES, -</u>		ADDRESS <u>SAME</u>	
18. <u>490X1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause [A] stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Pneumonitis</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Unknown.</u>	
		(B) <u>Asthmatic Bronchitis</u> DUE TO, OR AS A CONSEQUENCE OF:		<u>Many yrs.</u>	
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Congestive Heart Failure.</u>			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/16/72</u> 19__ to <u>1/17/72</u> 19__ that (I) (we) last saw the deceased alive on <u>1/17/72</u> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) <del>not</del> view the body after death.					
23A. SIGNATURE <u>[Signature]</u>		23B. DATE SIGNED <u>1/17/72</u>			
23C. PHYSICIAN'S NAME (Type) <u>DR. PENIKAR</u>		23D. ADDRESS <u>Lutheran Hospital</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Buried</u>		24B. DATE <u>1/21/72</u>		24C. NAME of CEMETERY or CREMATORY <u>St. Anthonys</u>	
24D. LOCATION (City, town, or county) (State) <u>Baltimore MD</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		25C. FUNERAL DIRECTOR <u>Myer &amp; Sons</u>	
		ADDRESS <u>635 N. G. &amp; N. A. S.</u>			



72 00681 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00681

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Mary C. Simms</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 18 72</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>475 Oxford Ct.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 18 72 2:20 p.</b>	
6. SEX <b>female</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1782</b>	
9. DATE OF BIRTH <b>JAN 3-1887</b>		10. AGE (In years last birthday) <b>85</b>	
11. BIRTHPLACE (State or foreign country) <b>BALTO MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>JOSEPH WHITE</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME <b>MARY BROWN</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO. <b>217-22-3618</b>		18. INFORMANT <b>Dr. Barnett 1218 K PRATON ST</b>	
19. CAUSE OF DEATH <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>1/22/72</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) DATE SIGNED <b>1/19/72</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE	
24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR	
25C. FUNERAL DIRECTOR		ADDRESS	

75 00681

75

Mr. J. H. White  
Mary Brown

Barre MD

217-12-3018

Enclosed for Mr. White is a check for \$10.00



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

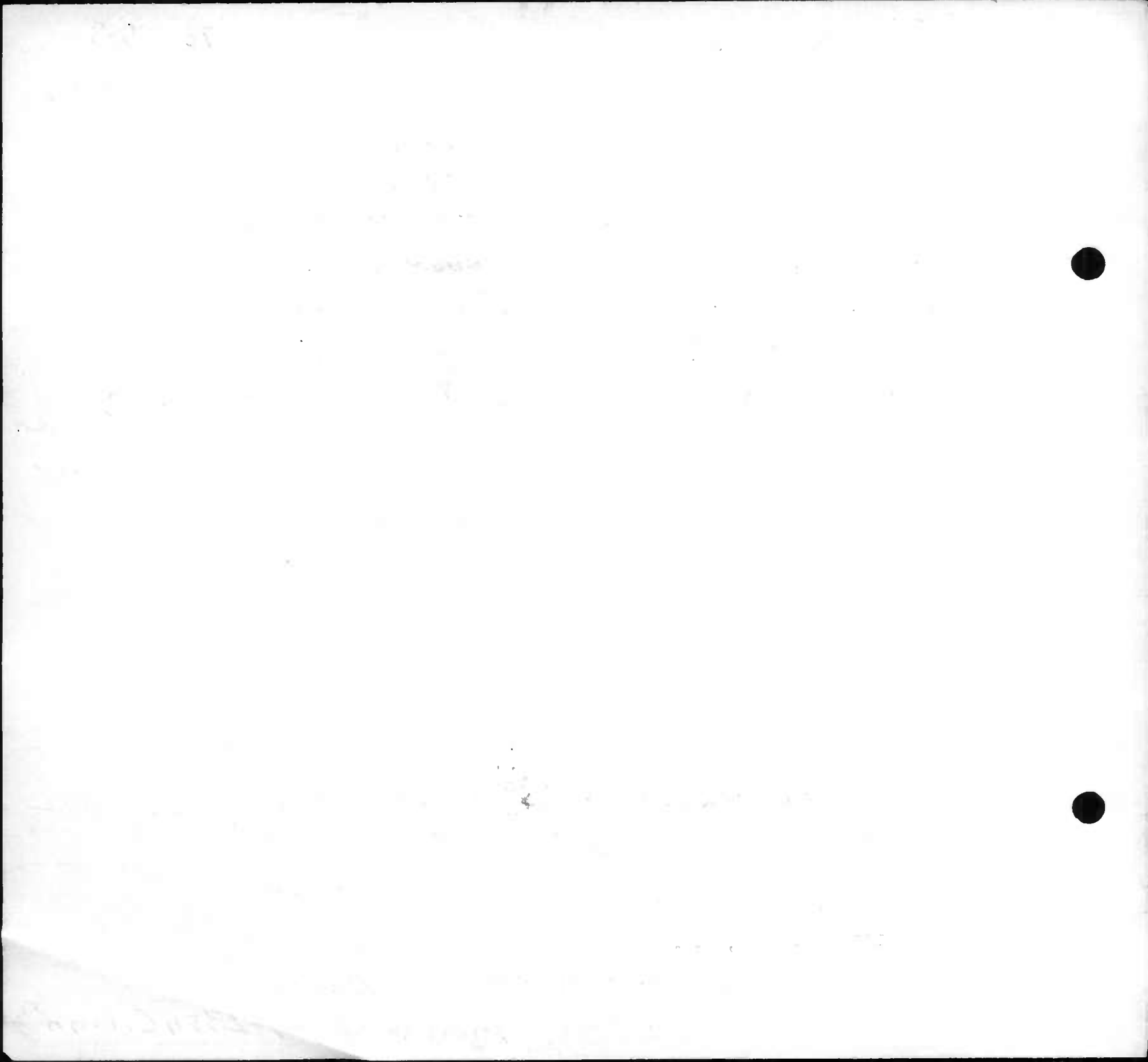
L-000		72 00682		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00682	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) Christopher Columbus Lee					
2. DATE AND HOUR OF DEATH 1/16/72 11:00 PM				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD Boltan Hill Nursing Home					
FULL NAME OF HOSPITAL OR INSTITUTION 1400 John Street Street Baltimore, Maryland				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 321 W. North Ave					
5. SEX Male		6. RACE Black		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 2/6/32		9. AGE (In years last birthday) 39 yrs.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CHAUFFEUR				10B. KIND OF BUSINESS OR INDUSTRY Freight Hauler				11. BIRTHPLACE (State or foreign country) Kensville VA	
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Robert E. Lee				14. MOTHER'S MAIDEN NAME Bannotis Rollis	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. 212-32-8730		17. INFORMANT Elizabeth Lee Collins 2331 Braddish Ave Baltimore			
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Coronary artery even retrovirus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year	
(B) DUE TO, OR AS A CONSEQUENCE OF:				(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from 1/13 1972 to 1/16 1972 that (I) (we) last saw the deceased alive on 1/16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Alan H. Macht				23B. DATE SIGNED 1/17/72		23C. PHYSICIAN'S NAME (Type) ALAN H. MACHT MD			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/19/72		24C. NAME OF CEMETERY or CREMATORY Mt Auburn		24D. LOCATION (City, town, or county) (State) BALTO MD			
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1972		25B. NAME OF REGISTRAR Robert E. Lee		25C. FUNERAL DIRECTOR James H. Vines		25D. ADDRESS 3885 J. Edgar St			

The first of the year  
has been a very  
successful one  
and we are  
glad to hear  
of the success  
of the  
first of the year  
and we are  
glad to hear  
of the success  
of the first of the year

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-000		72 00683		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00683	
BIRTH NO.				1. NAME OF DECEASED (Type or Print) <b>HORACE LEE Sr.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>MD Gen Hosp</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				2. DATE AND HOUR OF DEATH <b>JAN. 18, 1972 5:15 P.M.</b>			
4. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) A. STATE <b>Maryland</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				E. STREET AND NUMBER <b>1102 Druid Hill Avenue</b>			
5. SEX <b>Male</b>	6. RACE <b>Black</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>August 1904 67</b>		9. AGE On years last birthday <b>67</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NOT LABORER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CHEMICAL</b>		11. BIRTHPLACE (State or foreign country) <b>Southampton Co. VA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Jim Boyd</b>				14. MOTHER'S MAIDEN NAME <b>Mattie Loo</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-07-4639</b>		17. INFORMANT <b>HORACE LEE JR. 2511 BRADDOCK AVE</b>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>412.4 I</b> <b>ACVD &amp; Cardiac arrest - Permanent</b> <b>Cardiac Pacemaker</b> <b>Aortic Insufficiency</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cardiac Pacemaker</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Aortic Insufficiency</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>? 1 year</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>4/6 1971</b> to <b>1/18 1972</b> that (I) (we) last saw the deceased alive on <b>10/28 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Elijah Saunders</b>				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) <b>Elijah Saunders, M.D.</b>				23D. ADDRESS <b>2300 LIBERTY HEIGHTS - BALTO MD.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1/21/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>mt Arvon</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore</b>	
25A. DATE REC'D BY HEALTH/DEPT. <b>JAN 21 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley, M.D.</b>		25C. FUNERAL DIRECTOR <b>Major Harry A. Hays</b>		ADDRESS <b>1384 C. Linn</b>	



72 00684 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00684

BIRTH NO.

1. NAME OF DECEASED (Type or Print) George A. Coleman		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 1 17 72 11:10 P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 700 N. Appleton Street		3. DATE PRONOUNCED DEAD Month Day Year 1 17 72 11:10 P.M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH April 15-1908		10. AGE (In years last birthday) 63	
11. BIRTHPLACE (State or foreign country) Greenville Co Va		12. CITIZEN OF USA	
13. FATHER'S NAME JOHN COLEMAN		14. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1604	
15. MOTHER'S MAIDEN NAME ROTHA ANN JONES		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO.		18. INFORMANT F. A. WHITE 700 N Appleton St	
19. 412.4 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: disease (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) No		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Werner U. Spitz</i> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-18-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 1/21/72	
24C. NAME OF CEMETERY or CREMATORY Family Plot		24D. LOCATION (City, town, or county) (State) Greenville Co Va	
25A. DATE REC'D BY HEALTH DEPT JAN 21 1972		25B. NAME OF REGISTRAR Robert E. Taylor M.D.	
25C. FUNERAL DIRECTOR Marshall Phelps		ADDRESS 638 N. Gilman St	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

CERTIFICATE OF DEATH

REG. NO.

72 00685

BIRTH NO.

72 00685

1. NAME OF DECEASED  
(Type or Print)

Paulina Zebrowski

ZEBROWSKI

PAULINA

2. DATE AND HOUR OF DEATH

1/19/72

6-45 p.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) Church Home

Church Home Hosp.  
Baltimore Md. 21231

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY

Md. 21231

201

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

322 S CHESTER ST.

5. SEX

FEMALE WHITE

6. RACE

7. MARRIED ☐ NEVER MARRIED ☐

WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

12/26/86

9. AGE (In years last birthday)

85

10. Under 1 Yr. Months Days

11. Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

HOUSEWIFE

10B. KIND OF BUSINESS OR INDUSTRY

-

11. BIRTHPLACE (State or foreign country)

Poland

12. CITIZEN OF WHAT COUNTRY?

Poland

13. FATHER'S NAME

Joseph Ostrowski

HOUSTON ST. BALTIMORE

14. MOTHER'S MAIDEN NAME

Anna ???

ANNA OSTROWSKI

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

216-46-3257

17. INFORMANT

Mrs. Marie Zambrzycki

ADDRESS

322 S. Chester Street

18. CERTIFICATION APPROVED BY

DISEASE OR CONDITION DIRECTLY

CAUSE OF DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

1. Pulmonary Embolism

(B) DUE TO, OR AS A CONSEQUENCE OF:

2. Deep Vein Thrombosis

(C) DUE TO, OR AS A CONSEQUENCE OF:

3. 7x. recent Left femur

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

4-5 days

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

1/11/72

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

EX-LEFT FEMORAL

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

☒

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

CHURCH

21C. WHERE DID INJURY OCCUR?

BALTIMORE (CHESTER & BANK STS.)

21D. TIME OF INJURY (APPROX.)

1/4/72 AM

21E. INJURY OCCURRED While At Work ☐ Not While At Work ☒

21F. HOW DID INJURY OCCUR?

FALL

22. I certify that (I) (this hospital) attended the deceased from 1/4/72 to 1/19/72 and that (I) (we) last saw the deceased alive on 1/19/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

A. Mehta MD

Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23B. DATE SIGNED

1/19/72

23C. PHYSICIAN'S NAME (Type)

A. MEHTA MD

23D. ADDRESS

Church Home Hosp.

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/22/72

24C. NAME OF CEMETERY or CREMATORY

Holy Rosary

24D. LOCATION

Baltimore, Maryland

25A. DATE REC'D BY HEALTH DEPT.

JAN 21 1972

25B. NAME OF REGISTRAR

PAUL E. JALOWSKI

25C. FUNERAL DIRECTOR

M.F. SADOWSKI & SONS, 1808 EASTERN AVE

EXHIBIT 48

12-5-57 CHETA 4-24

1-1-58

WHITE

WHITE

1-1-58



1  
H 325

72 00686

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00686

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Thomas Hudson</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 18 72 4:45 A. M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 2123 W. North Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 18 72 4:45 A. M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
D. INSIDE CITY LIMITS? <b>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></b>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1503</b>	
9. DATE OF BIRTH <b>1-23-19</b>		10. AGE (In years last birthday) <b>52</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Arthur Thomas</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Self Employed</b>	
15. MOTHER'S MAIDEN NAME <b>Bertha Crippler</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)	
17. SOCIAL SECURITY NO. <b>216-16-6461</b>		18. INFORMANT <b>Mrs. Angela Paige 2232 Druid Hill</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>E965X</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Multiple gunshot wounds of chest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. DATE OF OPERATION <b>2</b>		21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>house</b>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>Rear room - 2123 W. North Avenue</b>		22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.) <b>1 18 72 4:50A.m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>shot during altercation</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz, M.D.</b> M.D. EXAMINER'S NAME (Type) DATE SIGNED <b>1-18-72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Wm. C. March</b>		25D. ADDRESS <b>928 E. North Ave.</b>	



THAYER

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B400 72 00687				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00687	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) BAILEY, Lonnie				2. DATE AND HOUR OF DEATH 1/20/72 1:15 a. m.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 2812 Walbrook Avenue			
5. SEX Male	6. RACE Negro	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH k 10/5/50	9. AGE (in years last birthday) 21	If Under 1 Yr. Months: Days:	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Steel Worker		10B. KIND OF BUSINESS OR INDUSTRY Bethlehem Steel		11. BIRTHPLACE (State or foreign country) Brooklyn, New York		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Lonnie Bailey				14. MOTHER'S MAIDEN NAME Cecilia Phillips			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-54-2670		17. INFORMANT Cecelia Bailey		ADDRESS 2812 Walbrook Ave.	
18. 5-7701 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Septic Shock		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3hr	
				(B) DUE TO, OR AS A CONSEQUENCE OF: Pneumonia		3hr	
				(C) Hemorrhagic Pancreatitis		5hr	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Massive Liver Failure							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 1/17/72 to 1/20/72 that (1) (we) last saw the deceased alive on 1/20/72 and that in (my) (your) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Wm Rohde MD				23B. DATE SIGNED 1/20/72			
23C. PHYSICIAN'S NAME (Type or Print) William A. Rohde, MD.				23D. ADDRESS The Johns Hopkins Hospital 601 N. Broadway Balto., Md.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-24-72		24C. NAME OF CEMETERY or CREMATORY Baltimore Cemetery		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Wm. C. March		ADDRESS 928 E. North Ave	

3W

Septic Shock

3W

~~Peritonitis~~

5W

Hemolytic Anemia

Massive Liver Failure

no

Yes

X

Cerebral Palsy

X

72 00688

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00688

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ROBERT A. GREEN</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>January</b> Day <b>19</b> Year <b>1972</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 1424 Argle Avenue</b>		3. DATE PRONOUNCED DEAD Month <b>January</b> Day <b>19</b> Year <b>1972</b> Hour <b>6:00 P.M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1402</b>			
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>10-2-28</b>		10. AGE (In years last birthday) <b>43</b>	
11. BIRTHPLACE (State or foreign country) <b>N.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>242388469</b>	
18. INFORMANT <b>Maude Johnson</b>		ADDRESS <b>1039 Mount St.</b>	
19. <b>780121</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Death apparently occurring during seizure</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C)	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 20, 1972</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-22-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Mem. Pk.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fahey, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Kelson F.H.</b>		ADDRESS <b>1348 Calhoun St.</b>	

• • • • •

1.  $\frac{1}{2}$  2.  $\frac{1}{3}$  3.  $\frac{1}{4}$  4.  $\frac{1}{5}$  5.  $\frac{1}{6}$  6.  $\frac{1}{7}$  7.  $\frac{1}{8}$  8.  $\frac{1}{9}$  9.  $\frac{1}{10}$  10.  $\frac{1}{11}$  11.  $\frac{1}{12}$  12.  $\frac{1}{13}$  13.  $\frac{1}{14}$  14.  $\frac{1}{15}$  15.  $\frac{1}{16}$  16.  $\frac{1}{17}$  17.  $\frac{1}{18}$  18.  $\frac{1}{19}$  19.  $\frac{1}{20}$  20.  $\frac{1}{21}$  21.  $\frac{1}{22}$  22.  $\frac{1}{23}$  23.  $\frac{1}{24}$  24.  $\frac{1}{25}$  25.  $\frac{1}{26}$  26.  $\frac{1}{27}$  27.  $\frac{1}{28}$  28.  $\frac{1}{29}$  29.  $\frac{1}{30}$  30.  $\frac{1}{31}$  31.  $\frac{1}{32}$  32.  $\frac{1}{33}$  33.  $\frac{1}{34}$  34.  $\frac{1}{35}$  35.  $\frac{1}{36}$  36.  $\frac{1}{37}$  37.  $\frac{1}{38}$  38.  $\frac{1}{39}$  39.  $\frac{1}{40}$  40.  $\frac{1}{41}$  41.  $\frac{1}{42}$  42.  $\frac{1}{43}$  43.  $\frac{1}{44}$  44.  $\frac{1}{45}$  45.  $\frac{1}{46}$  46.  $\frac{1}{47}$  47.  $\frac{1}{48}$  48.  $\frac{1}{49}$  49.  $\frac{1}{50}$  50.  $\frac{1}{51}$  51.  $\frac{1}{52}$  52.  $\frac{1}{53}$  53.  $\frac{1}{54}$  54.  $\frac{1}{55}$  55.  $\frac{1}{56}$  56.  $\frac{1}{57}$  57.  $\frac{1}{58}$  58.  $\frac{1}{59}$  59.  $\frac{1}{60}$  60.  $\frac{1}{61}$  61.  $\frac{1}{62}$  62.  $\frac{1}{63}$  63.  $\frac{1}{64}$  64.  $\frac{1}{65}$  65.  $\frac{1}{66}$  66.  $\frac{1}{67}$  67.  $\frac{1}{68}$  68.  $\frac{1}{69}$  69.  $\frac{1}{70}$  70.  $\frac{1}{71}$  71.  $\frac{1}{72}$  72.  $\frac{1}{73}$  73.  $\frac{1}{74}$  74.  $\frac{1}{75}$  75.  $\frac{1}{76}$  76.  $\frac{1}{77}$  77.  $\frac{1}{78}$  78.  $\frac{1}{79}$  79.  $\frac{1}{80}$  80.  $\frac{1}{81}$  81.  $\frac{1}{82}$  82.  $\frac{1}{83}$  83.  $\frac{1}{84}$  84.  $\frac{1}{85}$  85.  $\frac{1}{86}$  86.  $\frac{1}{87}$  87.  $\frac{1}{88}$  88.  $\frac{1}{89}$  89.  $\frac{1}{90}$  90.  $\frac{1}{91}$  91.  $\frac{1}{92}$  92.  $\frac{1}{93}$  93.  $\frac{1}{94}$  94.  $\frac{1}{95}$  95.  $\frac{1}{96}$  96.  $\frac{1}{97}$  97.  $\frac{1}{98}$  98.  $\frac{1}{99}$  99.  $\frac{1}{100}$  100.  $\frac{1}{101}$  101.  $\frac{1}{102}$  102.  $\frac{1}{103}$  103.  $\frac{1}{104}$  104.  $\frac{1}{105}$  105.  $\frac{1}{106}$  106.  $\frac{1}{107}$  107.  $\frac{1}{108}$  108.  $\frac{1}{109}$  109.  $\frac{1}{110}$  110.  $\frac{1}{111}$  111.  $\frac{1}{112}$  112.  $\frac{1}{113}$  113.  $\frac{1}{114}$  114.  $\frac{1}{115}$  115.  $\frac{1}{116}$  116.  $\frac{1}{117}$  117.  $\frac{1}{118}$  118.  $\frac{1}{119}$  119.  $\frac{1}{120}$  120.  $\frac{1}{121}$  121.  $\frac{1}{122}$  122.  $\frac{1}{123}$  123.  $\frac{1}{124}$  124.  $\frac{1}{125}$  125.  $\frac{1}{126}$  126.  $\frac{1}{127}$  127.  $\frac{1}{128}$  128.  $\frac{1}{129}$  129.  $\frac{1}{130}$  130.  $\frac{1}{131}$  131.  $\frac{1}{132}$  132.  $\frac{1}{133}$  133.  $\frac{1}{134}$  134.  $\frac{1}{135}$  135.  $\frac{1}{136}$  136.  $\frac{1}{137}$  137.  $\frac{1}{138}$  138.  $\frac{1}{139}$  139.  $\frac{1}{140}$  140.  $\frac{1}{141}$  141.  $\frac{1}{142}$  142.  $\frac{1}{143}$  143.  $\frac{1}{144}$  144.  $\frac{1}{145}$  145.  $\frac{1}{146}$  146.  $\frac{1}{147}$  147.  $\frac{1}{148}$  148.  $\frac{1}{149}$  149.  $\frac{1}{150}$  150.  $\frac{1}{151}$  151.  $\frac{1}{152}$  152.  $\frac{1}{153}$  153.  $\frac{1}{154}$  154.  $\frac{1}{155}$  155.  $\frac{1}{156}$  156.  $\frac{1}{157}$  157.  $\frac{1}{158}$  158.  $\frac{1}{159}$  159.  $\frac{1}{160}$  160.  $\frac{1}{161}$  161.  $\frac{1}{162}$  162.  $\frac{1}{163}$  163.  $\frac{1}{164}$  164.  $\frac{1}{165}$  165.  $\frac{1}{166}$  166.  $\frac{1}{167}$  167.  $\frac{1}{168}$  168.  $\frac{1}{169}$  169.  $\frac{1}{170}$  170.  $\frac{1}{171}$  171.  $\frac{1}{172}$  172.  $\frac{1}{173}$  173.  $\frac{1}{174}$  174.  $\frac{1}{175}$  175.  $\frac{1}{176}$  176.  $\frac{1}{177}$  177.  $\frac{1}{178}$  178.  $\frac{1}{179}$  179.  $\frac{1}{180}$  180.  $\frac{1}{181}$  181.  $\frac{1}{182}$  182.  $\frac{1}{183}$  183.  $\frac{1}{184}$  184.  $\frac{1}{185}$  185.  $\frac{1}{186}$  186.  $\frac{1}{187}$  187.  $\frac{1}{188}$  188.  $\frac{1}{189}$  189.  $\frac{1}{190}$  190.  $\frac{1}{191}$  191.  $\frac{1}{192}$  192.  $\frac{1}{193}$  193.  $\frac{1}{194}$  194.  $\frac{1}{195}$  195.  $\frac{1}{196}$  196.  $\frac{1}{197}$  197.  $\frac{1}{198}$  198.  $\frac{1}{199}$  199.  $\frac{1}{200}$  200.  $\frac{1}{201}$  201.  $\frac{1}{202}$  202.  $\frac{1}{203}$  203.  $\frac{1}{204}$  204.  $\frac{1}{205}$  205.  $\frac{1}{206}$  206.  $\frac{1}{207}$  207.  $\frac{1}{208}$  208.  $\frac{1}{209}$  209.  $\frac{1}{210}$  210.  $\frac{1}{211}$  211.  $\frac{1}{212}$  212.  $\frac{1}{213}$  213.  $\frac{1}{214}$  214.  $\frac{1}{215}$  215.  $\frac{1}{216}$  216.  $\frac{1}{217}$  217.  $\frac{1}{218}$  218.  $\frac{1}{219}$  219.  $\frac{1}{220}$  220.  $\frac{1}{221}$  221.  $\frac{1}{222}$  222.  $\frac{1}{223}$  223.  $\frac{1}{224}$  224.  $\frac{1}{225}$  225.  $\frac{1}{226}$  226.  $\frac{1}{227}$  227.  $\frac{1}{228}$  228.  $\frac{1}{229}$  229.  $\frac{1}{230}$  230.  $\frac{1}{231}$  231.  $\frac{1}{232}$  232.  $\frac{1}{233}$  233.  $\frac{1}{234}$  234.  $\frac{1}{235}$  235.  $\frac{1}{236}$  236.  $\frac{1}{237}$  237.  $\frac{1}{238}$  238.  $\frac{1}{239}$  239.  $\frac{1}{240}$  240.



T260

72 00689

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00689

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>ARTHUR TUCKER</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 817 N. Fremont Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 19, 1972 12:00 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>Negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1703</b>	
9. DATE OF BIRTH <b>5-9-02</b>		10. AGE (In years last birthday) <b>69</b>	
11. BIRTHPLACE (State or foreign country) <b>Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>construction</b>		14B. KIND OF BUSINESS OR INDUSTRY	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>2170999096</b>	
15. MOTHER'S MAIDEN NAME <b>Amanda</b>		18. INFORMANT ADDRESS <b>Louise Jones 961 St Nicholas Ave.</b>	
19. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 20, 1972</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1-24-72</b>	24C. NAME OF CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1972</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	25C. FUNERAL DIRECTOR V. Bailey ADDRESS <b>Kelson F.H. 1348 Calhoun St.</b>	





1  
WY 252

72 00690

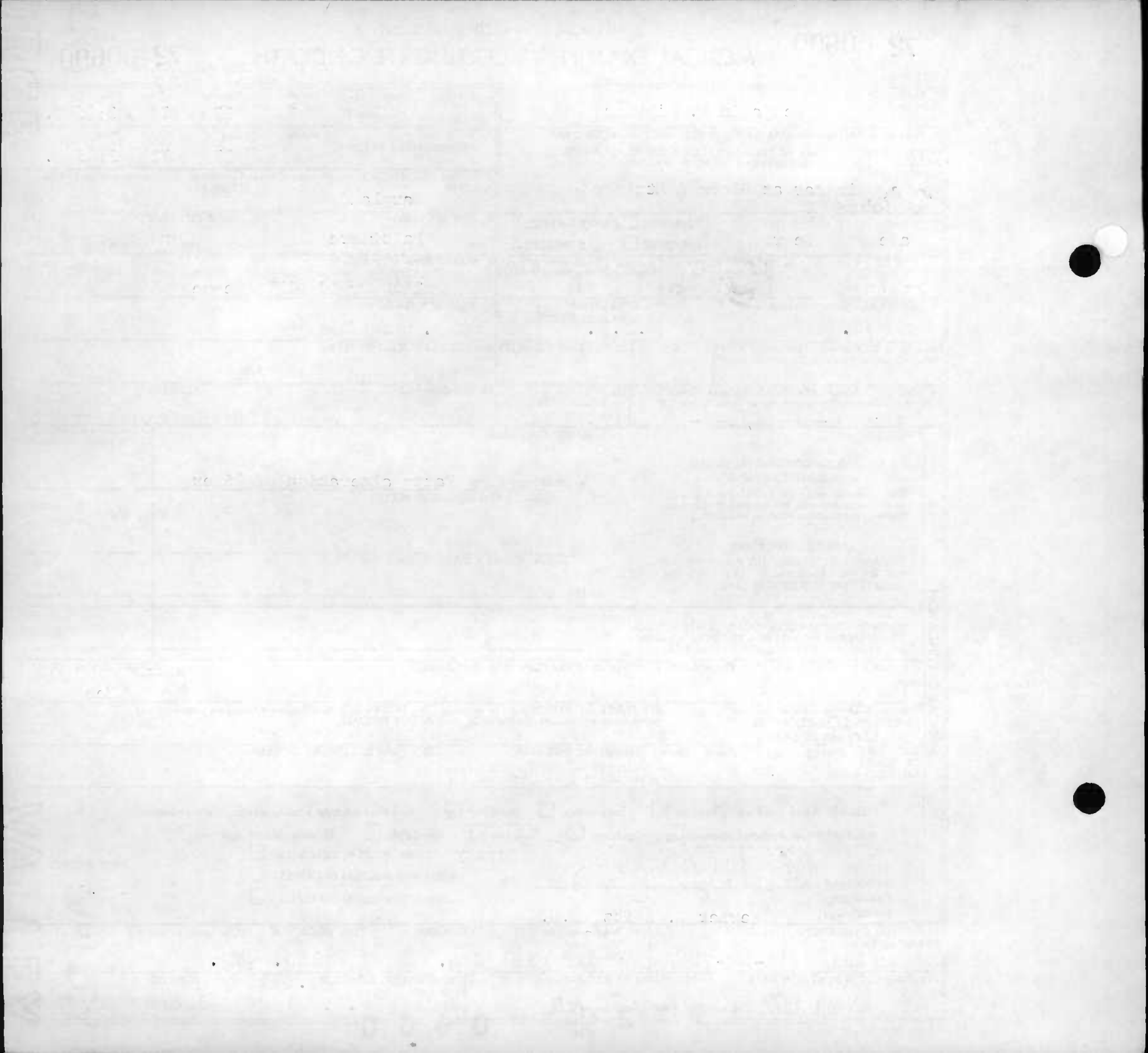
BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00690

BIRTH NO.

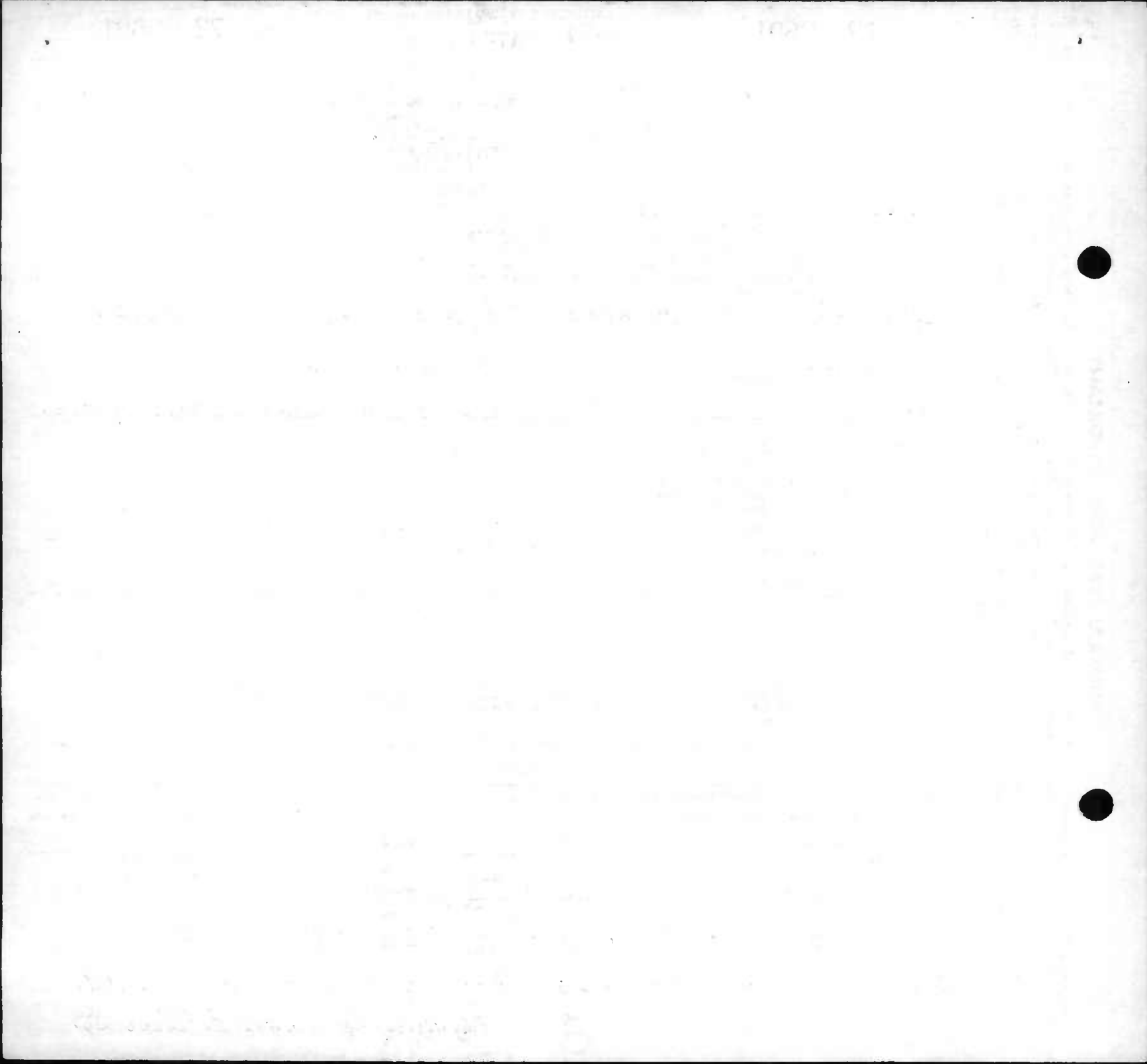
1. NAME OF DECEASED (Type or Print) Benjamin H. Wiggins		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> 1 17 72 3:45 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 00 in car at Bloom & Ettings		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 17 72 3:45 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 1403	
9. DATE OF BIRTH 3-17-14		10. AGE (in years lost birthday) 57	
11. BIRTHPLACE (State or foreign country) Va.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Benj. Wiggins		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME Clara Ross		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) yes 9-24-42-2-8-46	
17. SOCIAL SECURITY NO. 217017866		18. INFORMANT ADDRESS Charles Palmer 2128 Division Street	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 1-18-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-22-72	
24C. NAME OF CEMETERY or CREMATORY Cedar Hill Mem.		24D. LOCATION (City, town, or county) (State) Balto., Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR V. Bailey		ADDRESS Kelson F.H. 1348 Calhoun Street	



Susie Hall

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 00691</b>	
BIRTH NO. <b>72 00691</b>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>HALL, Susie H.</b>			2. DATE AND HOUR OF DEATH <b>1/20/72</b> <b>1:00 a.</b> <b>M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>808</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>33</b> <b>The Johns Hopkins Hospital</b>			C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			E. STREET AND NUMBER <b>1027 McDonough Street</b>		
5. SEX <b>Female</b>	6. RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/9/00</b>	9. AGE (In years last birthday) <b>71</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Lynchburg, Va.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>Nora Brown</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>?</b>		17. INFORMANT <b>Mrs Dorothy Adams 2021 Kennedy Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>412.2 + 250.9</b> <b>? Cardiac event</b> <b>minutes</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>? Viral Syndrome</b> <b>Diabetes Mellitus</b> <b>3 years</b> <b>8 days</b>			(B) DUE TO, OR AS A CONSEQUENCE OF: <b>HAS CVD + At Fibril.</b> <b>6+ years</b>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			(C) DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>		21. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21C. HOW DID INJURY OCCUR?	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <b>Jan 12, 1972</b> to <b>Jan 20, 1972</b> that (1) (we) last saw the deceased alive on <b>Jan 19, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Thomas K. Hodous M.D.</b>				23B. DATE SIGNED <b>Jan 20, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>Thomas K. Hodous, MD.</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-24-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Calvary Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Anne Arundel Co. Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1972</b>			
25B. NAME OF REGISTRAR <b>Robert E. Taber, R.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Randolph J. Collick 2431 E. Oliver St.</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

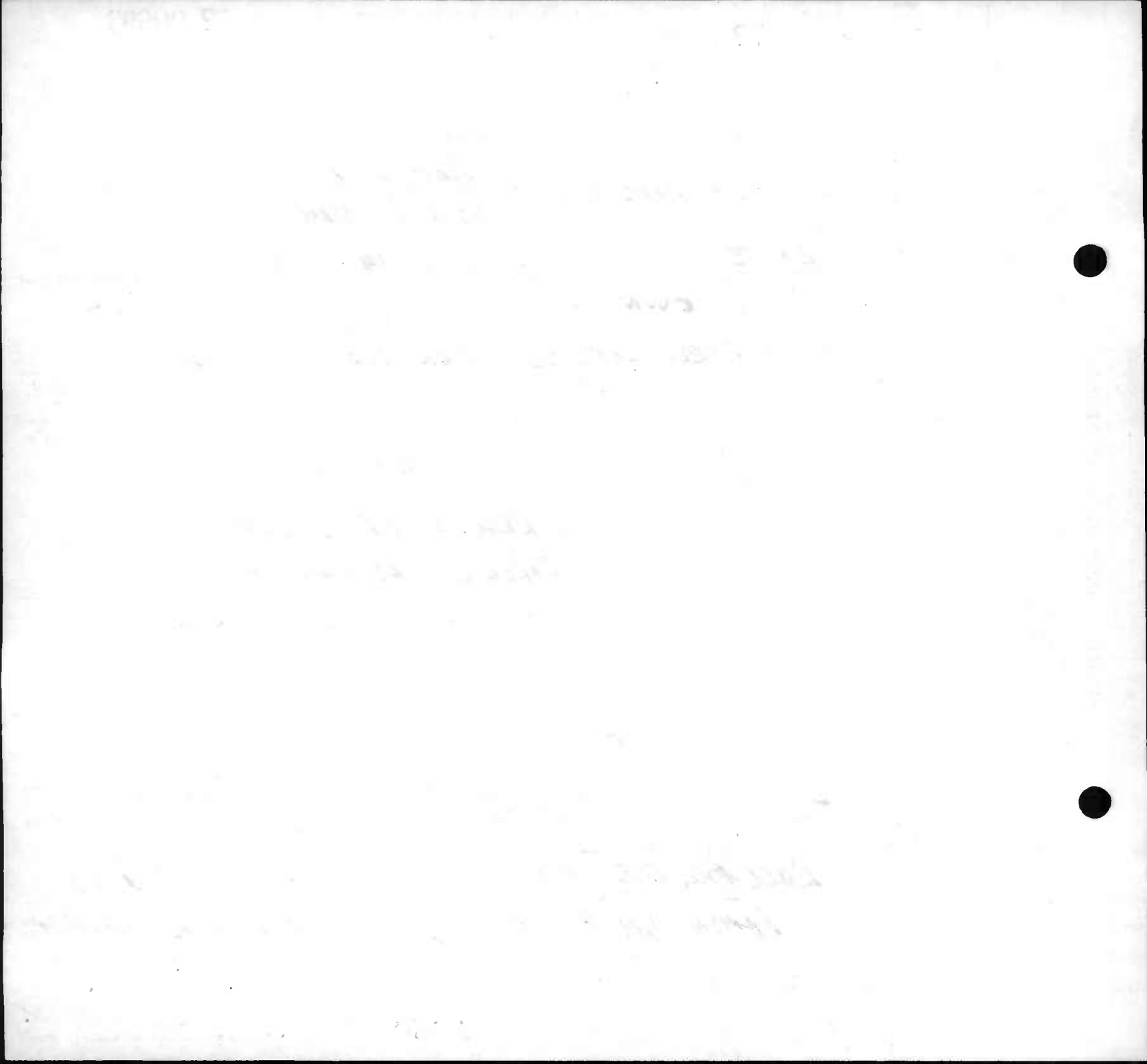
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00692</u>	
BIRTH NO. <u>72 00692</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Frances Capps</u>			2. DATE AND HOUR OF DEATH <u>1-16-72</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>2005 Kelly Ave.</u>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2755</u>		
FULL NAME OF HOSPITAL OR INSTITUTION <u>00</u>			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
E. STREET AND NUMBER <u>2005 Kelly Ave.</u>					
5. SEX <u>Female</u>	6. RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3-7-1891</u>	9. AGE (In years last birthday) <u>80</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Private</u>	11. BIRTHPLACE (State or foreign country) <u>Smithfield, Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Edward Curry</u>			14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>212-32-5335</u>	17. INFORMANT <u>Samuel Capps 2005 Kelly Ave.</u>		
18. <u>398X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>RHEUMATIC HEART DISEASE</u> (B) <u>CONGESTIVE HEART FAILURE</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>68 YRS</u> <u>6 YRS</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>NO</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>No</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <u>JAN. 28</u> 19 <u>66</u> to <u>JAN 16</u> 19 <u>72</u> , that (I) <del>last</del> last saw the deceased alive on <u>JAN 1</u> 19 <u>72</u> and that in (my) <del>last</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>did</del> (did) <del>not</del> view the body after death.					
23A. SIGNATURE <u>John M. Scott M.D.</u>				23B. DATE SIGNED <u>1/18/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>JOHN M. SCOTT</u>				23D. ADDRESS <u>600 W. NORTHERN PARKWAY BALTO MD 21210</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-20-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Mt. Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>Anne Arundel Co. Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Barber, M.D.</u>		25C. FUNERAL DIRECTOR <u>Rodolph J. Collick</u>	
				ADDRESS <u>2431 E. Oliver St.</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-520 72 00693				BALTIMORE CITY HEALTH DEPARTMENT		72 00693	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>KATHERINE HOPKINS KING</u>				2. DATE AND HOUR OF DEATH <u>1/21/72</u> <u>4:15 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1201</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 UNION MEMORIAL HOSPITAL</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>110 W 39th STREET</u>			
5. SEX <u>FEMALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>6-25-1910</u>		9. AGE (in years last birthday) <u>61</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOMEMAKER</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>WILLIAM MORSELL HOPKINS</u>				14. MOTHER'S MAIDEN NAME <u>CAMELLA DILLINGER</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>MRS. CAMILLA H. THOMAS TOWSON</u> ADDRESS <u>204 E. TOPPA Rd. BALTO. 21204</u>			
18. <u>57101</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>HEPATIC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(B) <u>CIRRHOSIS OF LIVER</u> DUE TO, OR AS A CONSEQUENCE OF:			
				(C) <u>CHRONIC ALCOHOLISM</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>HYPO ALBUMINEMIA - UREMIA</u>							
19A. DATE OF OPERATION <u>2/1</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>12/18/71</u> 19__ to <u>1/21/72</u> 19__ that (1) (we) last saw the deceased alive on <u>1/20/72</u> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Ramon de Busto MD</u>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/20/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>RAMON DE BUSTO</u>				23D. ADDRESS <u>UNION MEMORIAL HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/24/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1972</u>		25B. NAME OF REGISTRAR <u>Reed 72 2000</u>		25C. FUNERAL DIRECTOR <u>H.W. Jenkins &amp; Sons Co</u>		ADDRESS <u>4905 York Rd. Balto., Md. 21212</u>	

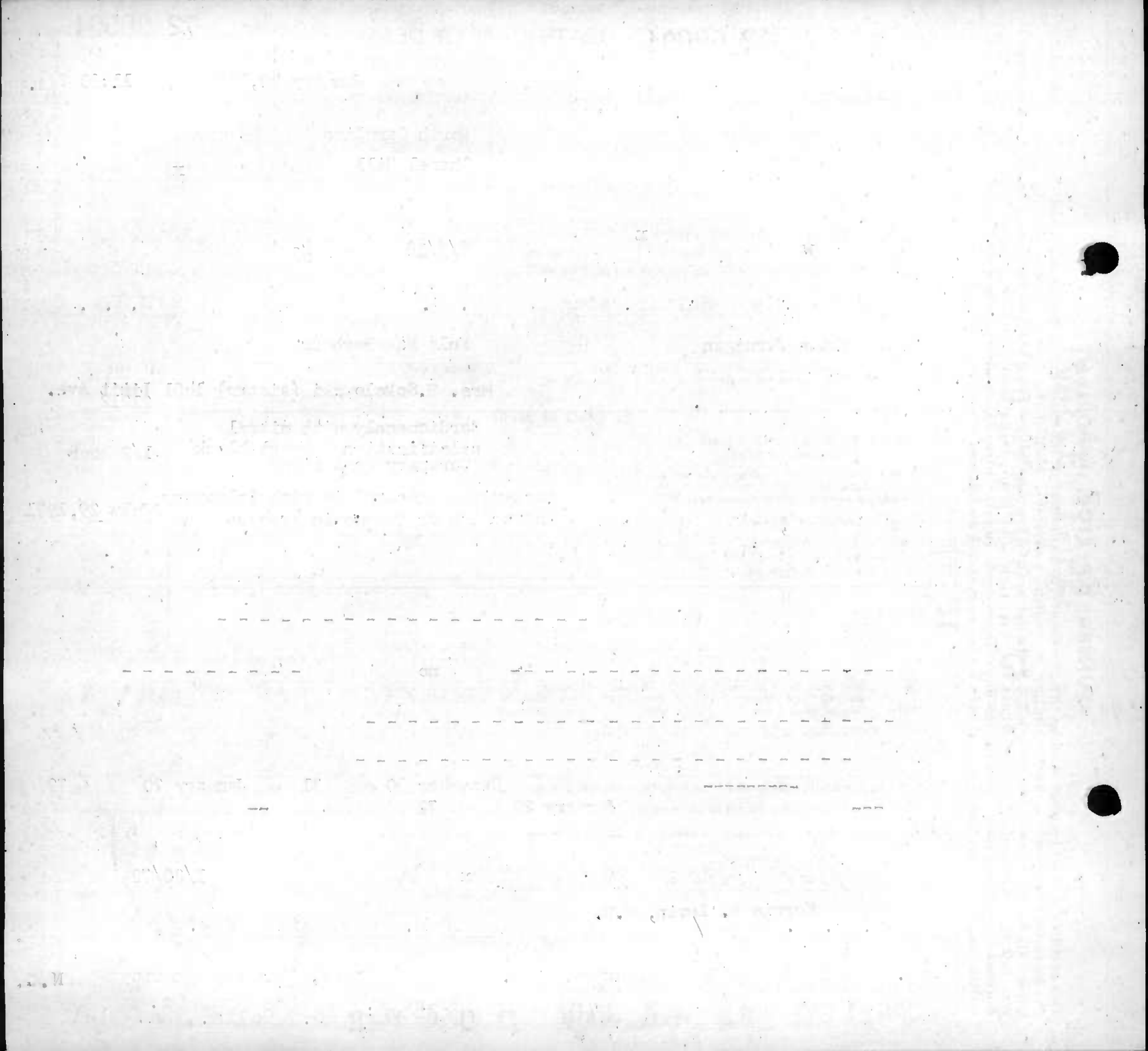




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

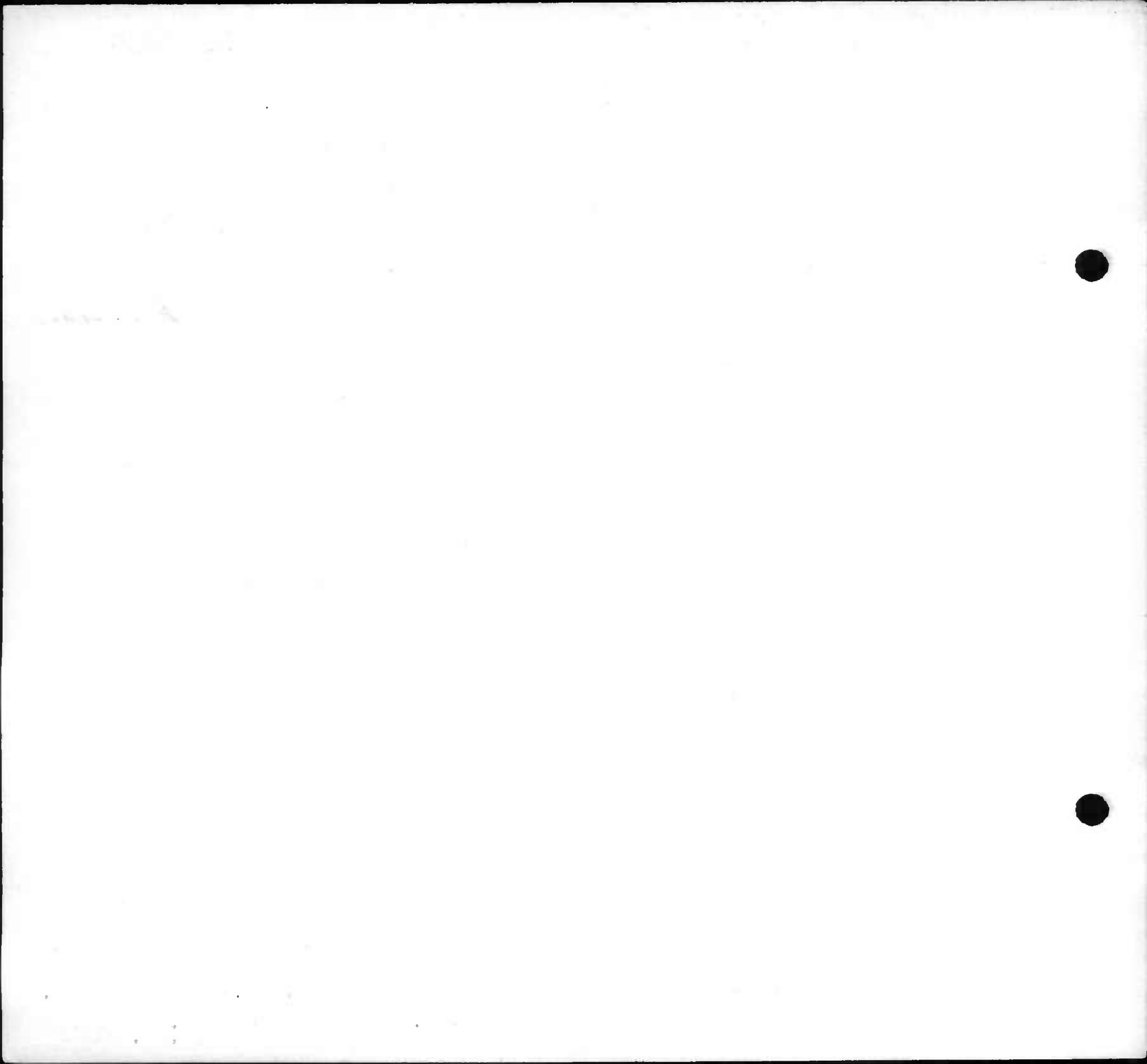
BALTIMORE CITY HEALTH DEPARTMENT									
BIRTH NO. <u>M-245</u> <u>72 00694</u>					CERTIFICATE OF DEATH <u>X</u> REG. NO. <u>72 00694</u>				
1. NAME OF DECEASED (Type or Print) <u>Pauline Jernigan Tart McLamb</u>					2. DATE AND HOUR OF DEATH <u>January 20, 1972</u> <u>11:30 ? A.M.</u>				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>44 Union Memorial Hospital</u>					4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>North Carolina</u> B. COUNTY <u>Harnett</u> C. CITY OR TOWN <u>Erwin</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER				
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/5/18</u>	9. AGE (In years last birthday) <u>53</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Proprietorship</u>			10B. KIND OF BUSINESS OR INDUSTRY <u>Hairdressing</u>		11. BIRTHPLACE (State or foreign country) <u>N. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>James Talton Jernigan</u>					14. MOTHER'S MAIDEN NAME <u>Eula Mae Barbour</u>				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. H. Sokolowski (sister) 1401 Limit Ave. 21212</u>				
18. <u>421.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  19A. DATE OF OPERATION <u>0</u> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  20A. AUTOPSY? (Yes or No) <u>no</u> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR?					CAUSE OF DEATH <u>Cardiomegaly with mitral calcification &amp; heart block</u> <u>Coronary Occlusion?</u> <u>Bacterial Endocarditis with Pulmonary Infarction or Pneumonic Process</u>  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> <u>July 29, 1971</u>				
MEDICAL CERTIFICATION									
22. I certify that (I) <del>(this hospital)</del> attended the deceased from <u>December 30</u> 19 <u>71</u> to <u>January 20</u> 19 <u>72</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>January 20</u> 19 <u>72</u> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.									
23A. SIGNATURE <u>M. B. Levin</u> DEGREE					Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>1/20/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Morris B. Levin, M.D.</u> <u>Dr. M. B. Levin</u> DEGREE					23D. ADDRESS <u>218 E. University Pkwy.</u>				
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Rem. Burial</u>			24B. DATE <u>1/20/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Greenwood Cem.</u>			24D. LOCATION (City, town, or county) (State) <u>Dunn, Harnett County N.C.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1972</u>			25B. NAME OF REGISTRAR <u>Henry W. Jenkins Sons Co.</u>			25C. FUNERAL DIRECTOR ADDRESS <u>01905 York Rd. Balto., Md. 21212</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

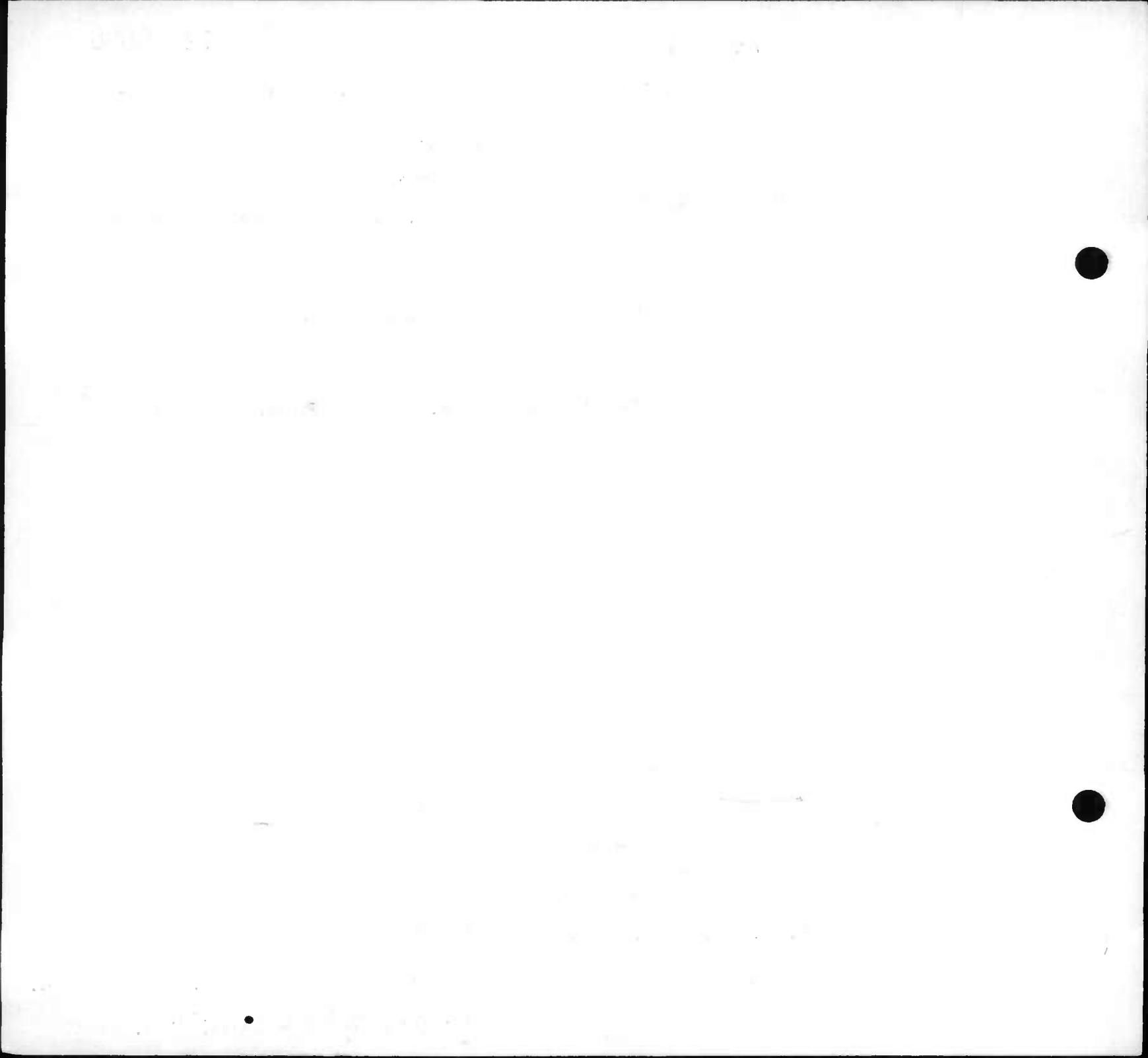
<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b>  <b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 00695</b></p>	
<p><b>BIRTH NO.</b> <b>E-430</b> <b>72 00695</b></p>			
<p><b>1. NAME OF DECEASED</b>          (Type or Print) <b>WILLIAM D. ELLIOTT</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b>  <b>1-17-72 2:35 P.M.</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>MD GEN. HOSPITAL</b></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)          A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b>          C. CITY OR TOWN <b>BALTO</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>          E. STREET AND NUMBER <b>6011 HUNTRIDGE RD.</b></p>	
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location)  <b>MD GEN. HOSPITAL</b></p>			
<p><b>5. SEX</b>  <b>M</b></p>	<p><b>6. RACE</b>  <b>W</b></p>	<p><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>  <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b>  <b>1/20/10</b></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)  <b>INSURANCE EXECUTIVE</b></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b>  <b>AM BASSADOR N.Y.</b></p>	
<p><b>11. BIRTHPLACE</b> (State or foreign country)  <b>ENGLAND</b></p>		<p><b>12. CITIZEN OF WHAT COUNTRY?</b>  <b>ENGLAND</b></p>	
<p><b>13. FATHER'S NAME</b>  <b>WILLIAM ELLIOTT</b></p>		<p><b>14. MOTHER'S MAIDEN NAME</b>  <b>MAUDE</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)  <b>No</b></p>		<p><b>16. SOCIAL SECURITY NO.</b></p>	
<p><b>17. INFORMANT</b>  <b>MRS. EUGENE L. O'BRIEN</b></p>		<p><b>ADDRESS</b>  <b>5914 BRACKENRIDGE AVE.</b></p>	
<p><b>18. CAUSE OF DEATH</b>  <b>I</b>  <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b>          (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  <b>Pulmonary congestion and edema</b>  <b>(A) IMMEDIATE CAUSE</b>  <b>DUE TO, OR AS A CONSEQUENCE OF:</b></p>		<p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b></p>	
<p><b>II</b>  <b>ANTECEDENT CAUSES</b>          DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>(B) Myocardial infarct - also</b>  <b>(C) Atherosclerotic cardiovascular disease</b></p>			
<p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>			
<p><b>19A. DATE OF OPERATION</b>  <b>2</b></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>	
<p><b>20A. AUTOPSY?</b> (Yes or No)  <b>Yes</b></p>		<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>  <b>Yes</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)  <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)  <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)  <b>(APPROX.)</b></p>		<p><b>21E. INJURY OCCURRED</b>          While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	
<p><b>21F. HOW DID INJURY OCCUR?</b></p>			
<p><b>22. I certify that (I) (this hospital) attended the deceased from <u>12-13</u> 19 <u>71</u> to <u>1-17</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1-17</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b>  <b>Beltran M.D.</b></p>		<p><b>23B. DATE SIGNED</b>  <b>1-18-71</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type)  <b>JUAN A. BELTRAN M.D.</b></p>		<p><b>23D. ADDRESS</b>  <b>MARYLAND GEN. HOSP.</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)  <b>Burial</b></p>		<p><b>24B. DATE</b>  <b>1-21-72</b></p>	
<p><b>24C. NAME OF CEMETERY or CREMATORY</b>  <b>Lorraine Park</b></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State)  <b>Balto. Co., Md.</b></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b>  <b>JAN 21 1972</b></p>		<p><b>25B. NAME OF REGISTRAR</b>  <b>John E. Jones, M.D.</b></p>	
<p><b>25C. FUNERAL DIRECTOR</b>  <b>O. J. Jenkins &amp; Sons Co.</b></p>		<p><b>ADDRESS</b>  <b>4905 York Road Balto. Md. 21212</b></p>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

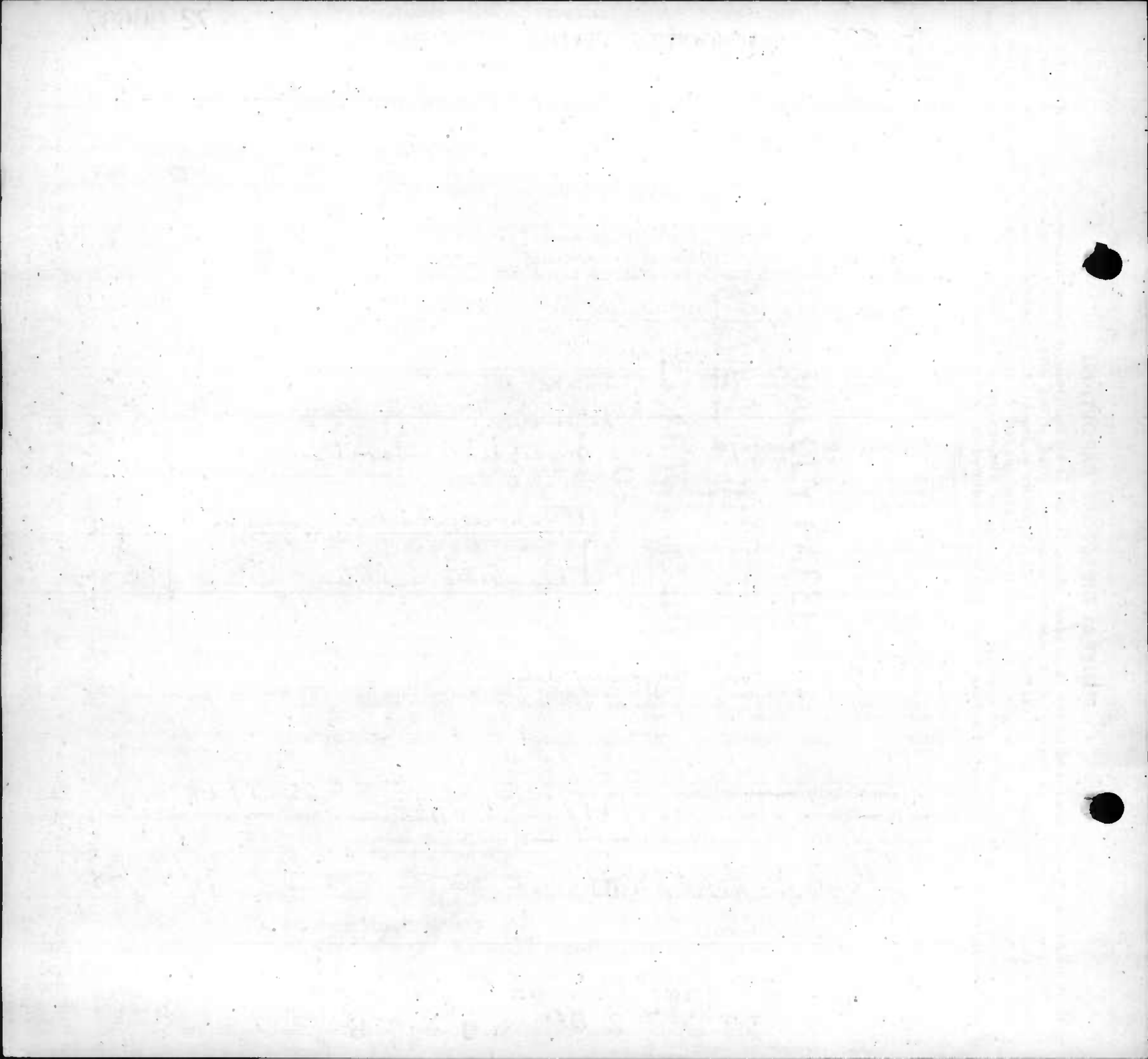
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00696</u>	
7-652 72 00696				CERTIFICATE OF DEATH	
BIRTH NO. <u>7-652</u>		1. NAME OF DECEASED (Type or Print) <u>Mamie C. Franz</u>		2. DATE AND HOUR OF DEATH <u>Jan. 18, 1972</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Edgewood Nursing Home</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1102</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>524 N. Charles Street 21201</u>		
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-2-1892</u>		9. AGE (In years last birthday) <u>79</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Boston, Mass.</u>	
13. FATHER'S NAME <u>?</u>			12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>212-01-3907 D</u>		17. INFORMANT <u>Mr. Charles Chlan 1 Charles Center</u>
18. <u>1830 I</u> CAUSE OF DEATH  DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>Carcinomatous</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Carcinoma of the ovary</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3+ mos</u>  <u>?</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Jan 14 1972</u> to <u>Jan 18 1972</u> that (I) ( <del>was</del> ) last saw the deceased alive on <u>Jan 18 1972</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>was</del> ) ( <del>did</del> ) view the body after death.					
23A. SIGNATURE <u>Frederick J. Vollmer MD</u>				23B. DATE SIGNED <u>1-20-72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Dr. Frederick J. Vollmer</u>				23D. ADDRESS <u>6100 York Road</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-21-72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Moreland Memorial Park</u>	
				24D. LOCATION (City, town, or county) (State) <u>Baltimore Co., Md.</u>	
25A. DATE OF DEATH <u>JAN 21 1972</u>		25B. NAME OF REGISTRAR <u>072000</u>		25C. FUNERAL DIRECTOR <u>H. W. Jenkins &amp; Sons Co.</u>	
				ADDRESS <u>4905 York Road Balto., Md. 21212</u>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00697	
BIRTH NO. 8-262				72 00697	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH	
Blanche Taylor Rogers				Jan. 19, 1972 4:40 P M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE Md. B. COUNTY 2712	
00 5101 St. Albans Way				C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 5101 St. Albans Way					
5. SEX F	6. RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-20-1900	9. AGE (In years last birthday) 71	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Teacher & Exec.			10B. KIND OF BUSINESS OR INDUSTRY Harbor Towing		11. BIRTHPLACE (State or foreign country) Moritacca, Va.
12. CITIZEN OF WHAT COUNTRY? USA			13. FATHER'S NAME William J. Taylor		
14. MOTHER'S MAIDEN NAME Sarah Hutchinson			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		
16. SOCIAL SECURITY NO. 220-14-0044			17. INFORMANT George E. Rogers Same		
18. 250.9 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)					
CAUSE OF DEATH myocardial infarction					
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: atherosclerotic cardiovascular disease					
(B) DUE TO, OR AS A CONSEQUENCE OF: Diabetes mellitus					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 12-28-71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED circulatory failure rt leg		20A. AUTOPSY? (Yes or No) no	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from 6/29 19 65 to 1/19 19 72, that (I) (we) last saw the deceased alive on 1/19 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE Paul G. Herold MD				23B. DATE SIGNED 1/20/72	
23C. PHYSICIAN'S NAME (Type) Dr. Paul G. Herold				23D. ADDRESS 10 W. Madison St.	
24A. BURIAL CREMATION, REMOVAL (Specify) Entombment		24B. DATE 1-22-72		24C. NAME OF CEMETERY OR CREMATORY Lorraine Park Mausoleum	
24D. LOCATION Baltimore		24E. (City, town, or county) Co.		24F. (State) Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 21 1972		25B. NAME OF REGISTRAR Robert E. Jenkins		25C. FUNERAL DIRECTOR H.W. Jenkins Sons Co. 4905 York Rd. Baltimore, Md. 21212	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 00698</span>				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">72 00698</span>	
1. NAME OF DECEASED (Type or Print) <b>HOFFMAN, Agnes H.</b>				2. DATE AND HOUR OF DEATH <b>1-20-72</b> <span style="float: right;"><b>6<sup>45</sup> a.m.</b></span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>91 Keswick</b> <b>700 West 40th St. - Baltimore, Md.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1201</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>116 W. University Pkwy.</b>							
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-11-85</b>		9. AGE (In years lost birthday) <b>87</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>James G. Boyd</b>				14. MOTHER'S MAIDEN NAME <b>Mary Atkinson</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>216-46-0292T</b>		17. INFORMANT <b>Keswick Records V. Crouch</b>	
18. <b>412.4 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral Vascular Accident</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic Cardiovas. Dis.</b> <b>Osteoarthritis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b> <b>6 months</b> <b>5 yrs</b>			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>30 Dec 1971</b> to <b>20 Jan 1972</b> , that (I) (we) last saw the deceased alive on <b>20 Jan 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Aubrey D. Richardson M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input checked="" type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>20 Jan 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>Aubrey D. Richardson, M.D.</b>				23D. ADDRESS <b>700 W. 40th Street</b>			
24A. BURIAL CREMATION, 24B. DATE REMOVAL (Specify) <b>Burial 1-22-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. J. [unclear]</b>		25C. FUNERAL DIRECTOR <b>H. W. Jenkins &amp; Sons Co.</b>		ADDRESS <b>4905 York Road Balto.; Md. 21212</b>	

2000-5

1000-1000

1000

1000

1000-1000

1000

1000

1000

1000

1000

1000

1000

1000

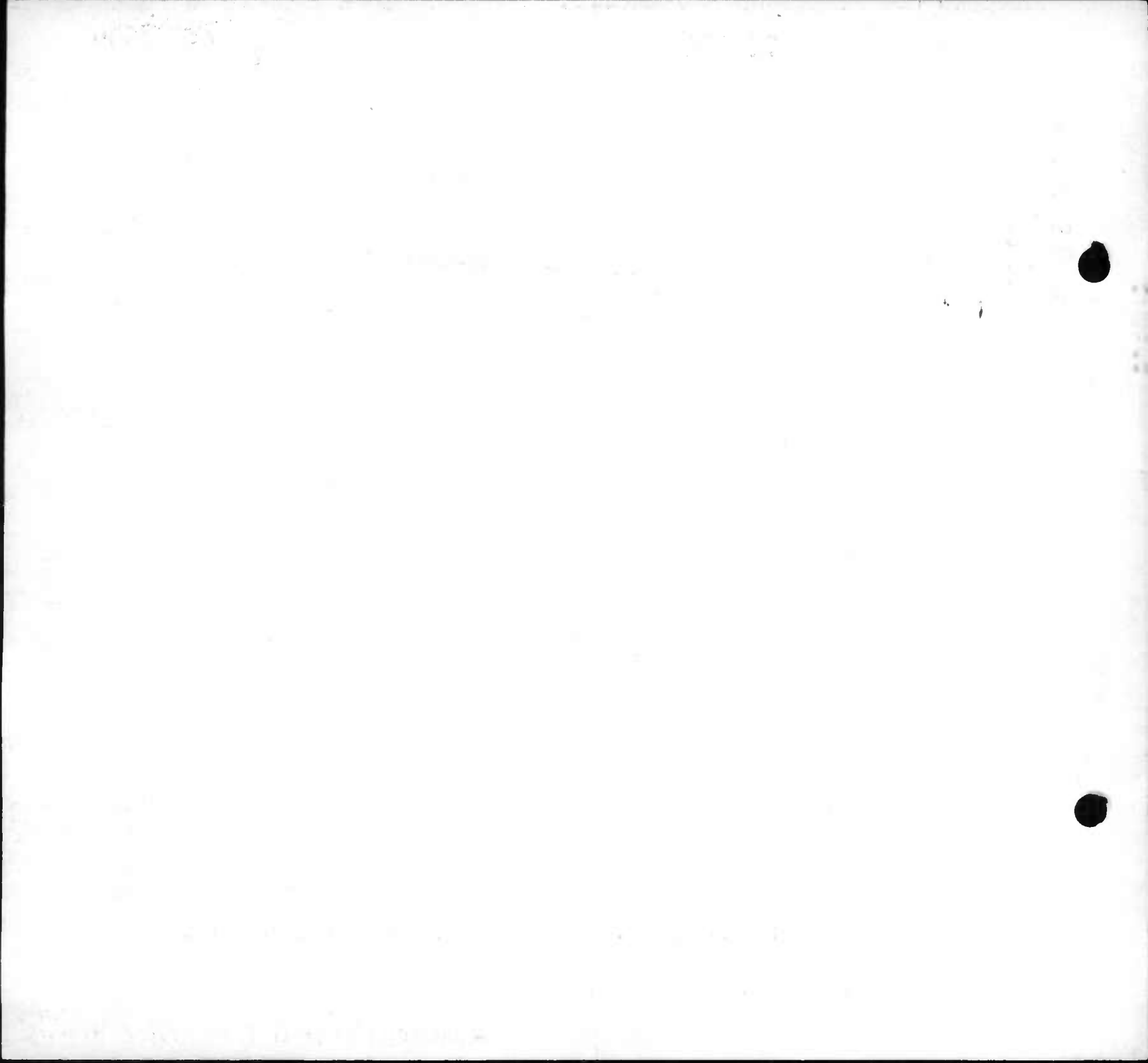
1000

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00699</b>	
<b>72 00699</b>		<b>CERTIFICATE OF DEATH</b>	
BIRTH NO. <b>J-250</b>		1. NAME OF DECEASED (Type or Print) <b>MINNIE NELSON JACKSON</b>	
2. DATE AND HOUR OF DEATH <b>JANUARY 19, 1972 3:15 A.M.</b>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>JOHNS HOPKINS HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2636</b>	
5. SEX <b>FEMALE</b> 6. RACE <b>NEGRO</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
8. DATE OF BIRTH <b>6-26-06</b> 9. AGE (In years last birthday) <b>65</b>		E. STREET AND NUMBER <b>6208 CARBONE WAY 21224</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FACTORY; DOMESTIC</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>CLOTHING</b>	
11. BIRTHPLACE (State or foreign country) <b>GREENVILLE, NC</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>NELSON, PETE</b>		14. MOTHER'S MAIDEN NAME <b>NELSON, LORENNA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <b>NO</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>PATRENS Melva Harris</b>		ADDRESS <b>6202 Carbone</b>	
18. <b>486X I</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Pneumonitis</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		<b>Myeloblastosis, Congestive Heart Failure</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 17 1972</b> to <b>January 19 1972</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 19 1972</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (not) view the body after death.			
23A. SIGNATURE <b>Robert E. Bast Jr MD</b>		23B. DATE SIGNED <b>1/19/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Robert Bast, Jr. MD</b>		23D. ADDRESS <b>The Johns Hopkins Hospital</b>	
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-22-72</b>	
24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Ba Ho, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Bast, Jr.</b>	
25C. FUNERAL DIRECTOR <b>Robert E. Bast, Jr.</b>		ADDRESS <b>1701-1705</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00700		REG. NO. 72 00700	
C-462				72 00700		72 00700	
BIRTH NO.				1. NAME OF DECEASED		2. DATE AND HOUR OF DEATH	
				Windsor C. Clark		1/19/72 9:00 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				Md. 1604			
1039 North Fulton Avenue				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				1039 North Fulton Avenue			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
M	N	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	1-31-1890	81			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?
			Balto Gas & Elec.		Kinston, North Carolina		U. S. A.
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Kagie Clark				Minerva Clark			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No		212-05-3248		Mrs. Bell Clark		1039 North Fulton Avenue	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		if days -	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				Broncho-pneumonia			
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Viral			
II				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1957 to Jan 19 1972 that (I) (we) last saw the deceased alive on Jan 18 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
JAMES S JULIAN JR MD				1/21/72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
JAMES S JULIAN JR MD				511 N. Schroeder St.			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1-24-72		Carver Memorial Park		Laurel, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 21 1972		E. J. J. J. J.		Morton & Dyett F. H.		1701 Laurens St.	

Page 1

Page 2

Page 3

Page 4

Page 5

Page 6

Page 7

Page 8

Page 9

Page 10

Page 11

Page 12

Page 13

Page 14

Page 15

Page 16

Page 17

1		72 00701		BALTIMORE CITY HEALTH DEPARTMENT		72 00701	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO.			
BIRTH NO.							
1. NAME OF DECEASED (Type or Print) <b>Frank A. Weston</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 19 72</b> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1713 N. Ashburton Street</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 19 72 8:15 a.</b> M.			
6. SEX <b>male</b>				7. RACE <b>Negro</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>June 30, 1913</b>				10. AGE (In years lost birthday) <b>58</b>		11. BIRTHPLACE (State or foreign country) <b>Leland, North Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>				13. FATHER'S NAME <b>Richard Weston</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
15. MOTHER'S MAIDEN NAME <b>Clar Tommer</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>215-03-0239</b>	
18. INFORMANT <b>Gladys Weston</b>				19. ADDRESS <b>1713 N. Ashburton St.</b>			
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive cardiovascular disease</b>				20. CAUSE OF DEATH <b>Hypertensive cardiovascular disease</b>			
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Diabetes Mellitus</b>				22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
20A. DATE OF OPERATION <b>6</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <b>no</b>				22. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			
22A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				22B. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22C. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Min.)				22D. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			
22E. HOW DID INJURY OCCUR?				23.			
<p>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/></p> <p>ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type): <b>Ronald N. Kornblum, M.D.</b></p> <p>CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/></p> <p>DATE SIGNED: <b>1/19/72</b></p>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-22-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Morton &amp; Dyett F. H. 1701 Laurens St.</b>			

X

June 20, 1952

John, Fort, Carolina

Richard, Boston

Clair, Boston

11-12-52 11-12-52 11-12-52 11-12-52 11-12-52

11-12-52 11-12-52 11-12-52 11-12-52 11-12-52

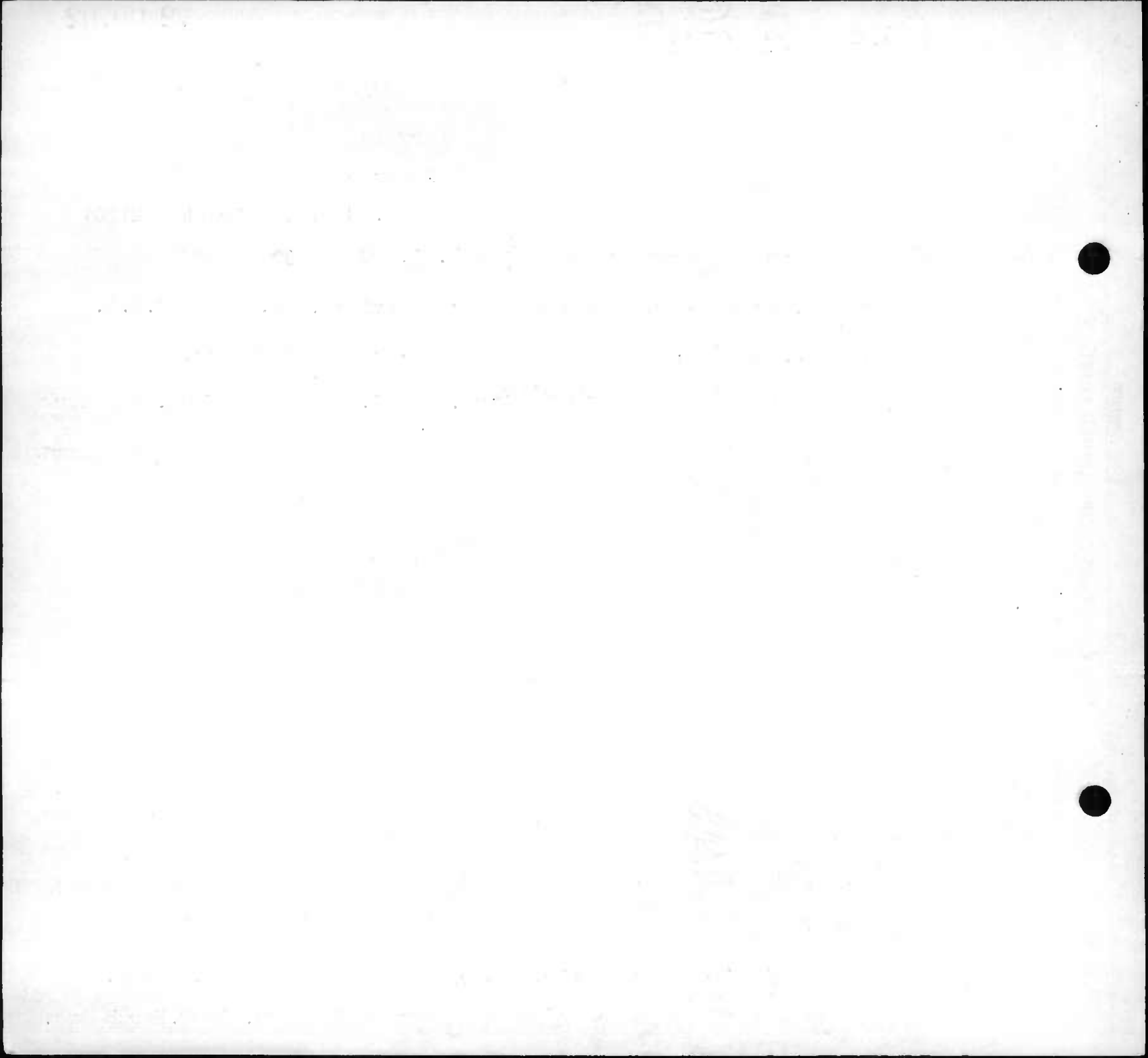
11-12-52 11-12-52 11-12-52 11-12-52 11-12-52



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

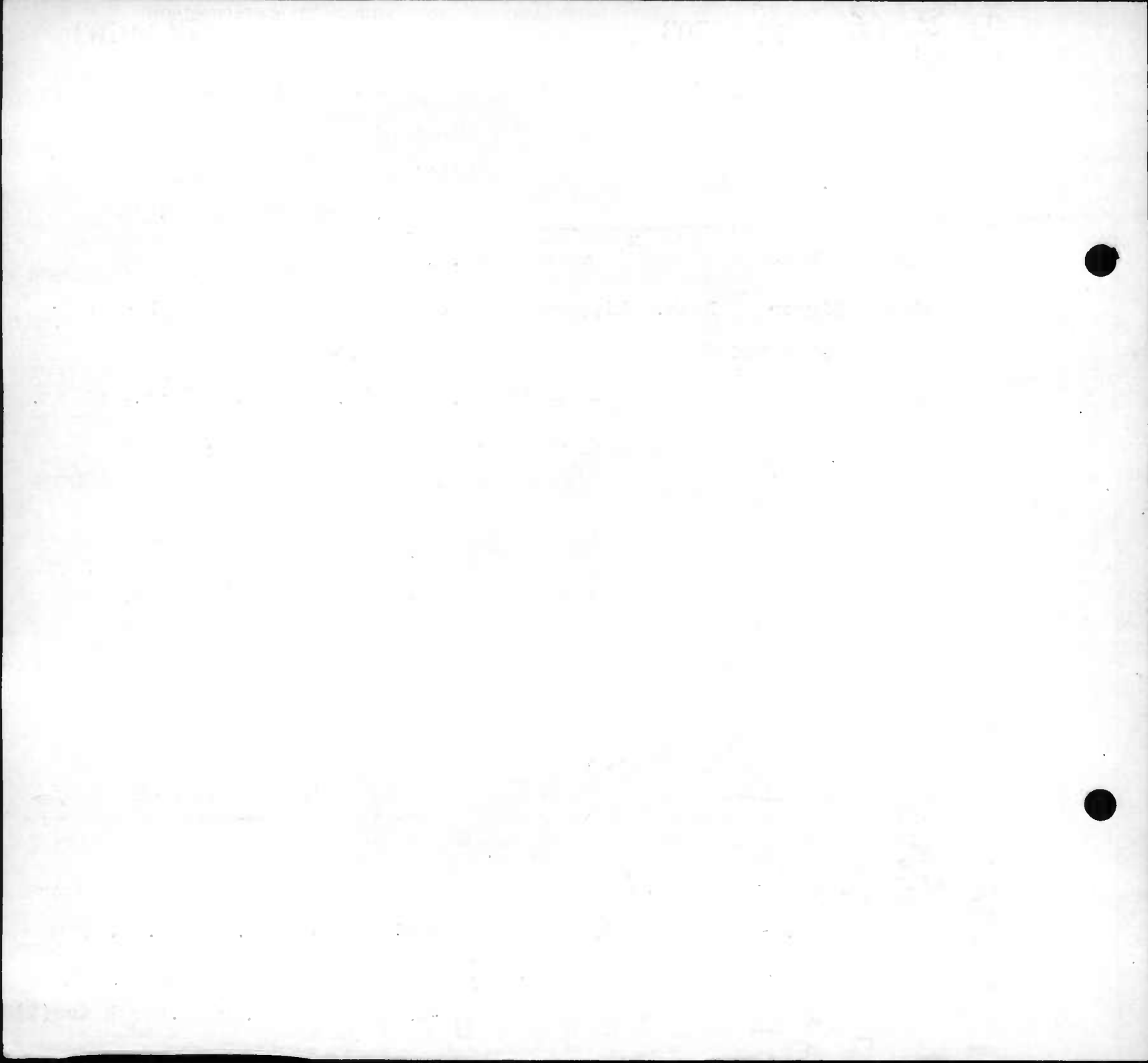
Baltimore City Health Department				72 00702		72 00702	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
EDNA BELLE KENNEY				January 19, 1972 4:45 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE B. COUNTY			
00 Walbert Apartments				Maryland 1205			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				1800 N. Charles Street 21201			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Feb. 3, 1902	69			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Retired Reg. Nurse				Baltimore City		Connellsville, Pa.	
12. CITIZEN OF WHAT COUNTRY?				U.S.A.			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Joseph Kenney				Daisy Belle Gibbons			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
No				214-40-5906			
17. INFORMANT				ADDRESS			
Sister:				Mrs. Mara K. Swank, New York, New York			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)				19 Months 19 Months			
19. ANTECEDENT CAUSES							
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.							
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)				21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
				While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from October 8, 1966 to January 19, 1972, that (I) (we) last saw the deceased alive on January 18, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED	
W. Grafton Hersperger						January 20, 1972	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
W. Grafton Hersperger				214 Medical Arts Building			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1/21/72		Husband Cemetery		Somerset, Penna.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
JAN 21 1972		Robert E. Taylor, M.D.		STEWART & MOWEN CO.		108 W. North Ave. 21201	



FUNERAL DIRECTOR: IMPORTANT

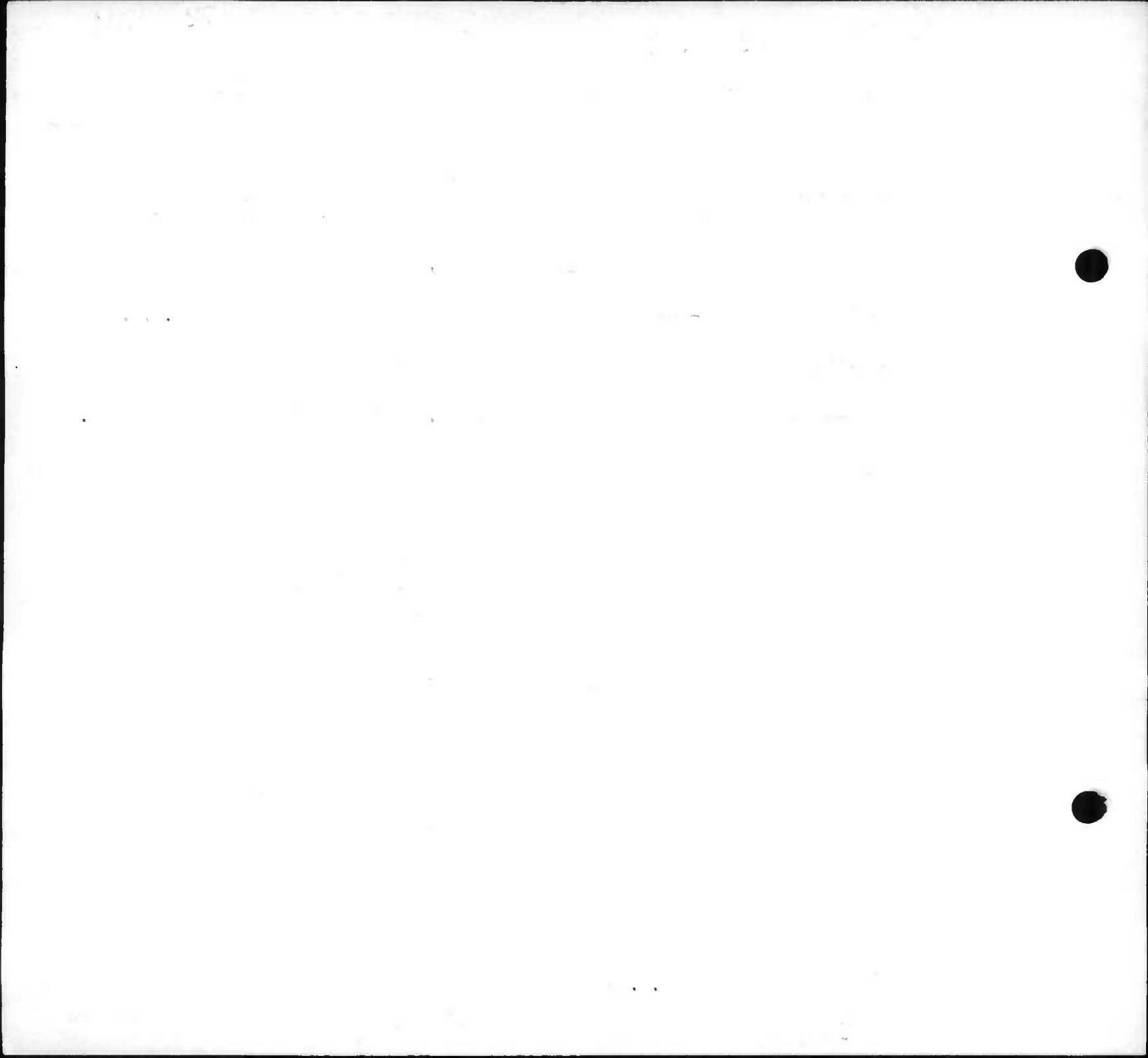
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00703</b>	
B-324 72 00703		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>TITUS (NMN) BUDGELL</b>		2. DATE AND HOUR OF DEATH <b>Jan. 19, 1972 9<sup>56</sup> A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1818 St. Paul Street</b> <b>00</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1205</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1818 St. Paul Street, 21218</b>	
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 4, 1908</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Rigger</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Shipyard</b>	9. AGE (In years last birthday) <b>63</b>
11. BIRTHPLACE (State or foreign country) <b>Newfoundland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Heber Budgell</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Boone</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-10-9558</b>	
17. INFORMANT <b>Wife:</b>		ADDRESS <b>21218</b> <b>Mrs. Freda C. Budgell, 1818 St. Paul St.</b>	
18. <b>4 12 41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic C-V Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (A) IMMEDIATE CAUSE (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this <del>hospital</del> ) attended the deceased from <b>Jan. 1971</b> to <b>Jan. 19 1972</b> , that (I) (we) last saw the deceased alive on <b>Jan 11 19 72</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>William H. Fusting, M. D.</b>		23B. DATE SIGNED <b>1-26-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>William H. Fusting, M. D.</b>		23D. ADDRESS <b>4230 Loch Raven Blvd., Balto. Md. 21212</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Gardens of Faith</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore County, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fusting, M.D.</b>	
25C. FUNERAL DIRECTOR <b>STEWART &amp; MOWEN CO.</b>		ADDRESS <b>108 W. North Ave (1)</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

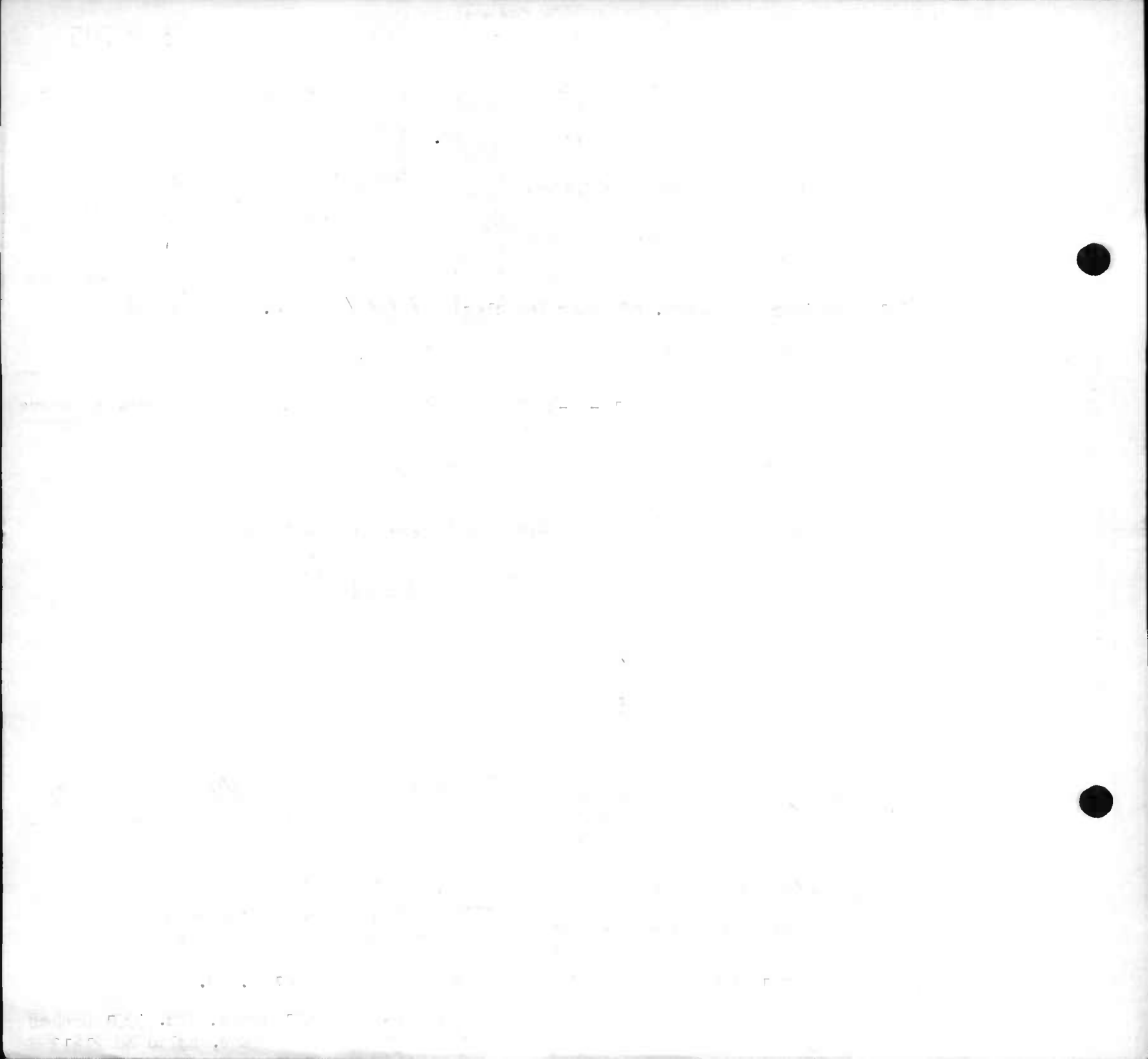
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00704</u>
BIRTH NO. <u>7-452</u>		72 00704		
1. NAME OF DECEASED (Type or Print) <u>May T Fillingner</u>		2. DATE AND HOUR OF DEATH <u>January 19 1972</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 16 West Barney Street Baltimore 21230 Maryland</u>		A. STATE <u>2303</u> B. COUNTY		
		C. CITY OR TOWN <u>Baltimore Maryland</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
		E. STREET AND NUMBER <u>16 West Barney Street Balto 21230 Md</u>		
5. SEX <u>F</u>	6. RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 25, 1896</u>	9. AGE (In years last birthday) <u>75</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>John Neill</u>		14. MOTHER'S MAIDEN NAME <u>unknown</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Leo L. Fillingner 4106 5th Street Balto. #25</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Occlusion in</u> <u>Myocardial CV Disease</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Cerebral Vascular Accident</u> (C) <u>Diabetes Mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-4 days</u> <u>years</u> <u>1968</u> <u>years</u>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>4/19/65</u> 19 to <u>1/19/72</u> 19 that (I) (we) last saw the deceased alive on <u>1/18</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>Walter Kohn</u>		23B. DATE SIGNED <u>1/19/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>WALTER KOHN MD</u>		23D. ADDRESS <u>102 E. Fort Ave</u>		
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE	24C. NAME OF CEMETERY or CREMATORY <u>U.S. National Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>5501 Frederick Road ( Maryland )</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1972</u>	25B. NAME OF REGISTRAR <u>Robert J. 207-23 0 0 0</u>	25C. FUNERAL DIRECTOR <u>McCall's Funeral Home 130 East Fort Ave</u>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-220 BIRTH NO.		72 00705		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00705	
1. NAME OF DECEASED (Type or Print) JAMES KOZAK (Kozak)				2. DATE AND HOUR OF DEATH 1/16/72 5:35 AM					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 THE UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2608					
5. SEX M 6. RACE W 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 03-27-06		9. AGE (In years last birthday) 65		10. IF UNDER 1 Yr. Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Title Examiner				10B. KIND OF BUSINESS OR INDUSTRY Dept. of Motor Vehicles				11. BIRTHPLACE (State or foreign country) Virk, Md.	
12. CITIZEN OF WHAT COUNTRY USA				13. FATHER'S NAME VACLAV KOZAK				14. MOTHER'S MAIDEN NAME MARIE	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. 217-22-4297		17. INFORMANT Peoris Kozak (wife)			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: pulmonary emboli. (B) Artensclerosis cardiovascular DUE TO, OR AS A CONSEQUENCE OF: diabetes. (C) old history of HT.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) yes		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNOERLTING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1/12 1972 to 1/16 1972 that (I) (we) last saw the deceased alive on 1/16 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Harclo Faw-chiang				23B. DATE SIGNED 1/16/72		23C. PHYSICIAN'S NAME (Type) TZEN-CHI FAN-CHIANG			
24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL				24B. DATE 1/19/72		24C. NAME OF CEMETERY or CREMATORY Meadowridge Cemetery		24D. LOCATION (City, town, or county) (State) Bal to. Md.	
25A. DATE RECEIVED BY HEALTH DEPT. JAN 21 1972				25B. NAME OF REGISTRAR 12720000		25C. FUNERAL DIRECTOR Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Bal to Md 21213			





**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

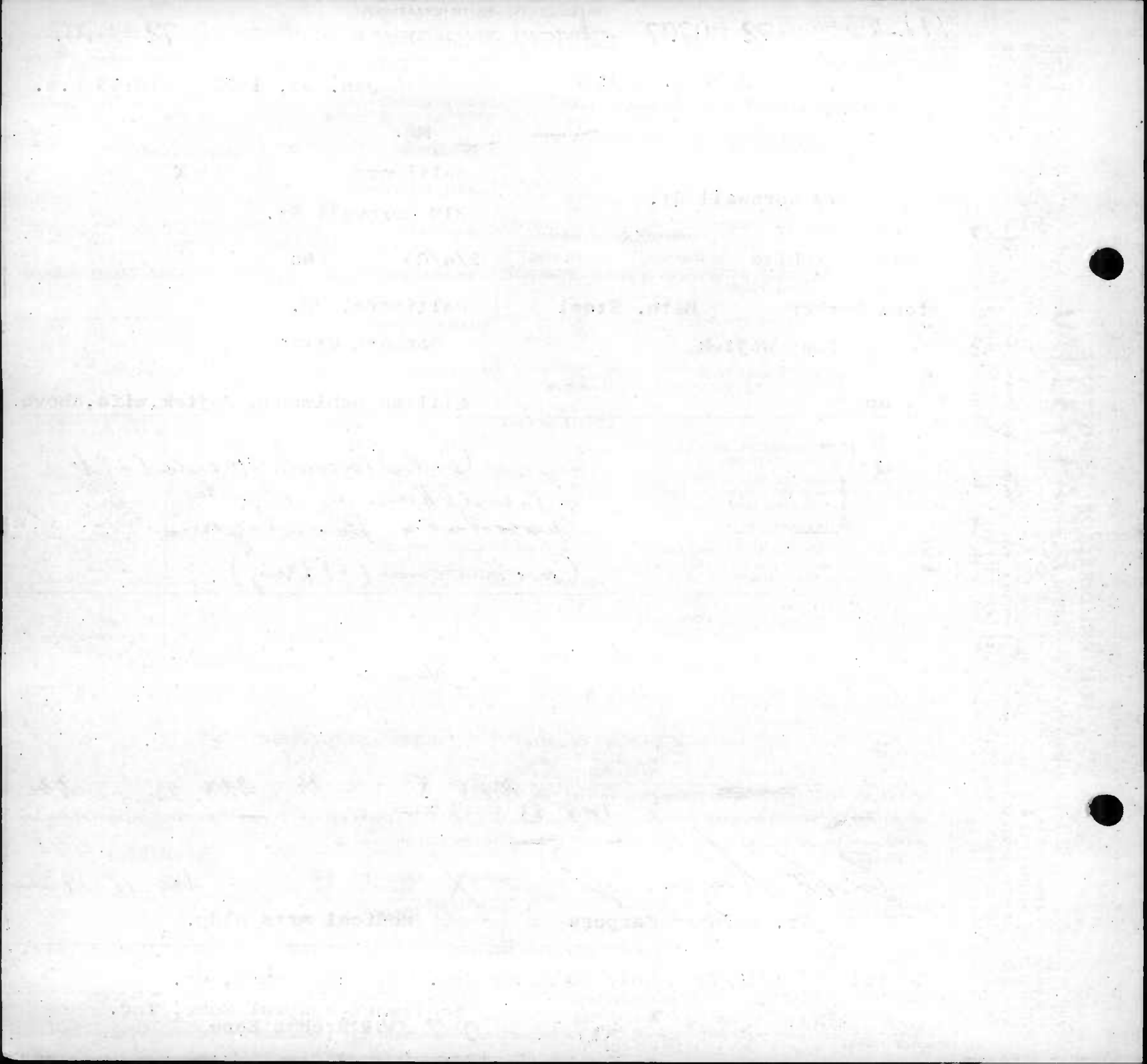
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00706</span>	
8-352 72 00706		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
William Leslie Steinacker		Jan. 16, 1972 11:30 p. M.		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
00 3415 Brendan Avenue		Md., 21213		CITY OR TOWN	
00 3415 Brendan Avenue		Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		3415 Brendan Avenue		F. DATE OF BIRTH	
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
male		white		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Waiter		Sportsman Lodge		Baltimore, Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
Alvin Steinacker		Julia Tuttle		U.S.A.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
				Mrs Joan Collins, neice, 3501 Brendan Ave.	
18. 157.0 I		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		Metastatic cancer	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) Carcinoma head of pancreas over 1 yr.			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
(C) _____					
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from _____ 19 _____ to _____ 19 _____, that (I) (we) last saw the deceased alive on Dec 27, 19 71 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Dr. John J. Krejci MD				1-17-72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
Dr. John J. Krejci				2 E. Read St.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1/20/72		New Cathedral Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 21 1972		Robert E. Taylor, M.D.		Schimunek Funeral Home, Inc.	
				3331 Brehms Lane	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embolmed or final disposition is made.

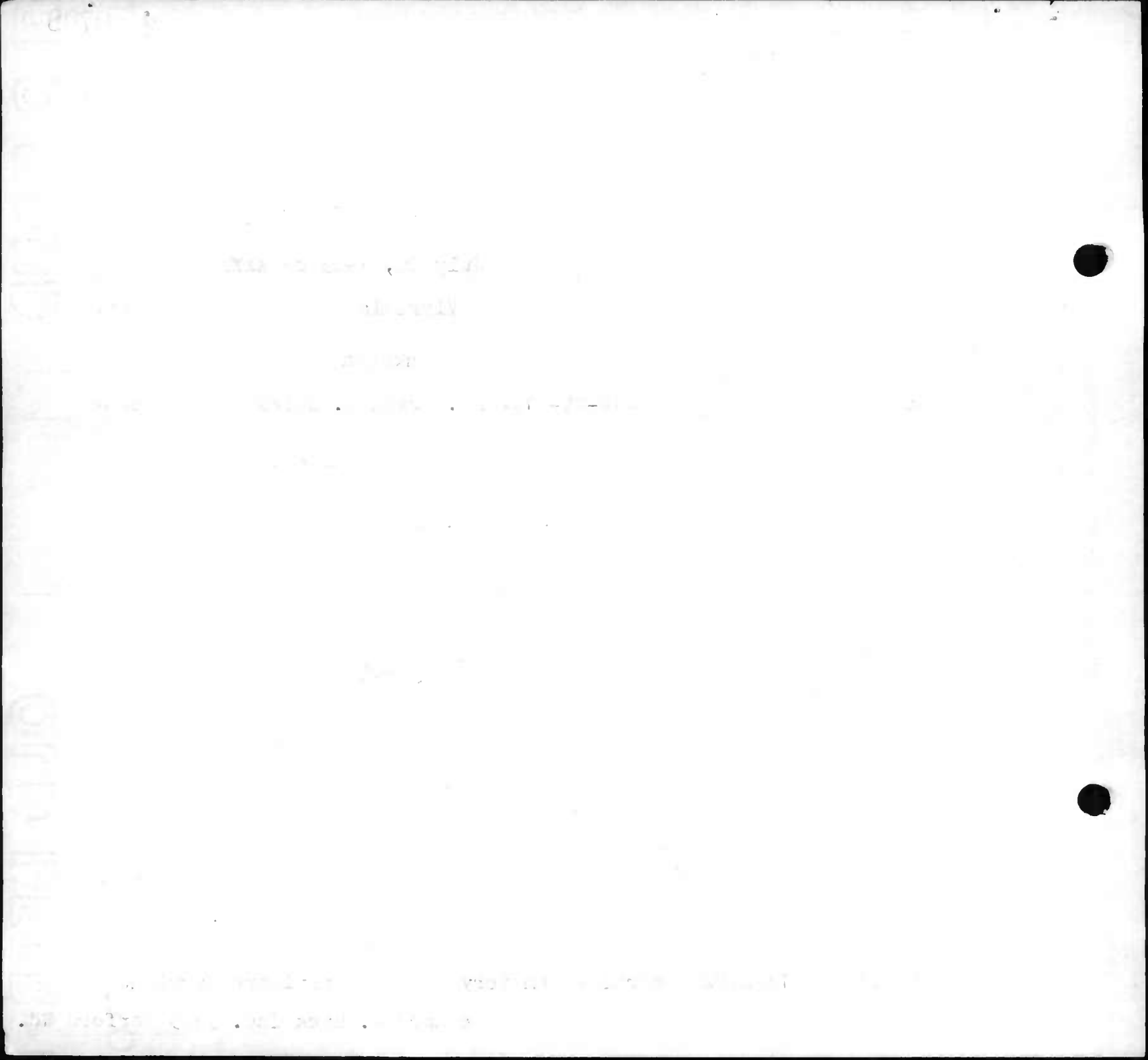
BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 00707</u>	
<b>1. NAME OF DECEASED</b> (Type or Print) <b>John L. Wojtek</b>				<b>2. DATE AND HOUR OF DEATH</b> <b>Jan. 13, 1972</b> <b>10:55 p.m.</b>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 319 Cornwall St.</b>				<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2605</b> <b>C. CITY OR TOWN</b> <b>Baltimore</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>319 Cornwall St.</b>			
<b>5. SEX</b> <b>male</b>		<b>6. RACE</b> <b>white</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>2/4/05</b>	
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Beth. Steel</b>		<b>9. AGE</b> (In years last birthday) <b>66</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Md.</b>	
<b>13. FATHER'S NAME</b> <b>John Wojtek</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Barbara Vitak</b>			
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <b>Lillian Schimunek Wojtek, wife, above</b> <b>ADDRESS</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>162.1 I</b> <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Cerebral Vascular Accident 2° to</b> <b>due to, or as a consequence of:</b> <b>infarcted heart due to</b> <b>myocardial infarction</b> (B) <b>due to, or as a consequence of:</b> <b>Coronary (Rt Lung)</b> (C) <b>Antecedent Causes</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>20 to</b>			
<b>19A. DATE OF OPERATION</b> <b>0 NONE</b>				<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>No</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)				<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)				<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>MAY 5</b> <b>1971</b> <b>to</b> <b>JAN 13</b> <b>1972</b> , <b>that (I) (we) last saw the deceased alive on</b> <b>JAN 13</b> <b>1972</b> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>							
<b>23A. SIGNATURE</b> <b>Dr. Bernard Karpers</b>				<b>23B. DATE SIGNED</b> <b>JAN. 15, 1972</b>		<b>23C. PHYSICIAN'S NAME</b> (Type) <b>Dr. Bernard Karpers</b> <b>23D. ADDRESS</b> <b>Medical Arts Bldg.</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>24B. DATE</b> <b>1/18/72</b>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Holy Redeemer Cem.</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Md.</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 21 1972</b>		<b>25B. NAME OF REGISTRAR</b> <b>Robert E. [unclear]</b>		<b>25C. FUNERAL DIRECTOR</b> <b>Schimunek Funeral Home, Inc.</b>		<b>ADDRESS</b> <b>3331 Brehms Lane</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

8-420		72 00708		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00708	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <b>MADIE SOLES</b>				2. DATE AND HOUR OF DEATH <b>JAN 17-72 4 40 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE UNION MEMORIAL HOSPITAL</b>				A. STATE <b>MD</b> B. COUNTY <b>2733</b>			
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <b>F</b> 6. RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <b>July 26, 1903</b> 9. AGE (In years last birthday) <b>68</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>				11. BIRTHPLACE (State or foreign country) <b>Virginia</b>			
10B. KIND OF BUSINESS OR INDUSTRY				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
13. FATHER'S NAME <b>PUCKETT</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>212-09-9132</b>			
17. INFORMANT <b>Mr. Frank L. Soles</b>				ADDRESS <b>Same</b>			
18. <b>202.21</b> CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>SEPTICEMIA -</b>							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>LINPHOMA -</b>							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> 19 <b>72</b> to <b>1/17</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/17</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Joe Paz</b>				23B. DATE SIGNED <b>1/17/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>JOSE PAZ</b>				23D. ADDRESS <b>THE UNION MEMORIAL HOSP.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Lorraine Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1972</b>		25B. NAME OF REGISTRAR <b>Robert J. J. Ruck</b>		25C. FUNERAL DIRECTOR <b>Leonard J. Ruck Inc.</b>		ADDRESS <b>5305 Harford Rd.</b>	

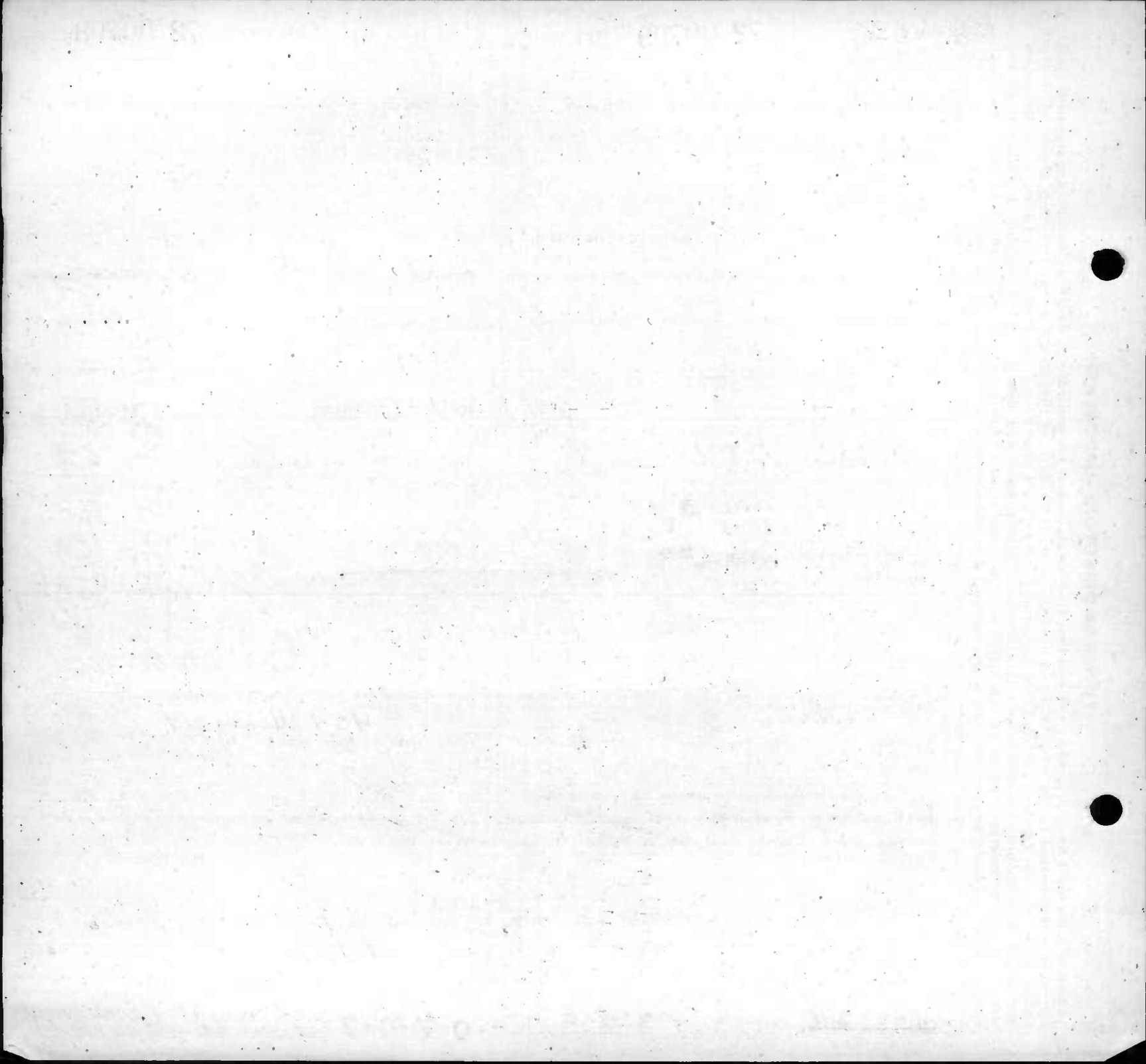


FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>H-630</b>      <b>72 00709</b>      <b>CERTIFICATE OF DEATH</b>      <b>REG. NO. 72 00709</b></p>	
<p><b>BIRTH NO.</b></p>	
<p><b>1. NAME OF DECEASED</b> (Type or Print) <b>WINFIELD R. HOWARD.</b></p>	
<p><b>2. DATE AND HOUR OF DEATH</b> <b>January, 18, 1972 12 a.m.</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>	
<p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3 SOUTH Baltimore General Hospital</b> <b>3001 S. Hanover St.</b></p>	
<p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) <b>A. STATE</b> <b>Maryland</b>      <b>B. COUNTY</b> <b>2402</b></p>	
<p><b>C. CITY OR TOWN</b> <b>Baltimore</b>      <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p><b>E. STREET AND NUMBER</b> <b>1454 Henry Street</b></p>	
<p><b>5. SEX</b> <b>Male</b>      <b>6. RACE</b> <b>White</b>      <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/>      <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	
<p><b>8. DATE OF BIRTH</b> <b>August 26, 1898</b>      <b>9. AGE</b> (In years last birthday) <b>73</b></p>	
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>      <b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>Beth Steel</b></p>	
<p><b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>      <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b></p>	
<p><b>13. FATHER'S NAME</b> <b>William Howard</b>      <b>14. MOTHER'S MAIDEN NAME</b> <b>Rachael ??</b></p>	
<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>      <b>16. SOCIAL SECURITY NO.</b> <b>213-10-6167</b>      <b>17. INFORMANT</b> <b>Matilda C. Howard</b>      <b>ADDRESS</b> <b>1454 Henry Street</b></p>	
<p><b>18. CAUSE OF DEATH</b></p>	
<p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, etc. It means the disease, injury or complication which caused death.) <b>Possible Pulmonary Embolism</b></p>	
<p><b>ANTECEDENT CAUSES</b> DISEASES, OR CONDITIONS, if any, leading rise to the above cause and making the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Possible Pulmonary Embolism</b>      <b>1 hour</b></p>	
<p><b>(B) Long standing hypertension myocardial infarction</b>      <b>10 years</b></p>	
<p><b>(C) Possible fracture H. hip</b>      <b>24 hours</b></p>	
<p><b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <b>Fracture Left Hip</b></p>	
<p><b>19A. DATE OF OPERATION</b> <b>0</b>      <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>-</b>      <b>20A. AUTOPSY?</b> (Yes or No) <b>No</b>      <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>      <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Home</b>      <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>1454 Henry St.</b></p>	
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.) <b>Jan., 17 1972 10am</b>      <b>21E. INJURY OCCURRED</b> <b>While At Work</b> <input type="checkbox"/> <b>Not While At Work</b> <input checked="" type="checkbox"/>      <b>21F. HOW DID INJURY OCCUR?</b> <b>FELL DOWN.</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>January, 17 1972</b> <b>to</b> <b>January, 18 1972</b>, <b>that (I) (we) last saw the deceased alive on</b> <b>January, 18 1972</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>	
<p><b>23A. SIGNATURE</b> <b>Chumhak Pongsapong</b> <b>M.D.</b> <b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/>      <b>23B. DATE SIGNED</b> <b>January, 18, 1972</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>CHUMSAK PRUKSAPONG</b> <b>M.D.</b>      <b>23D. ADDRESS</b> <b>South Baltimore General Hospital</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>Burial</b>      <b>24B. DATE</b> <b>1/21/72</b>      <b>24C. NAME OF CEMETERY or CREMATORY</b> <b>Western Cemetery</b>      <b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore Maryland</b></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 21 1972</b>      <b>25B. NAME OF REGISTRAR</b> <b>Robert E. [unclear]</b>      <b>25C. FUNERAL DIRECTOR</b> <b>McCurly Funeral Homes</b> <b>130 E. Fort Avenue</b></p>	



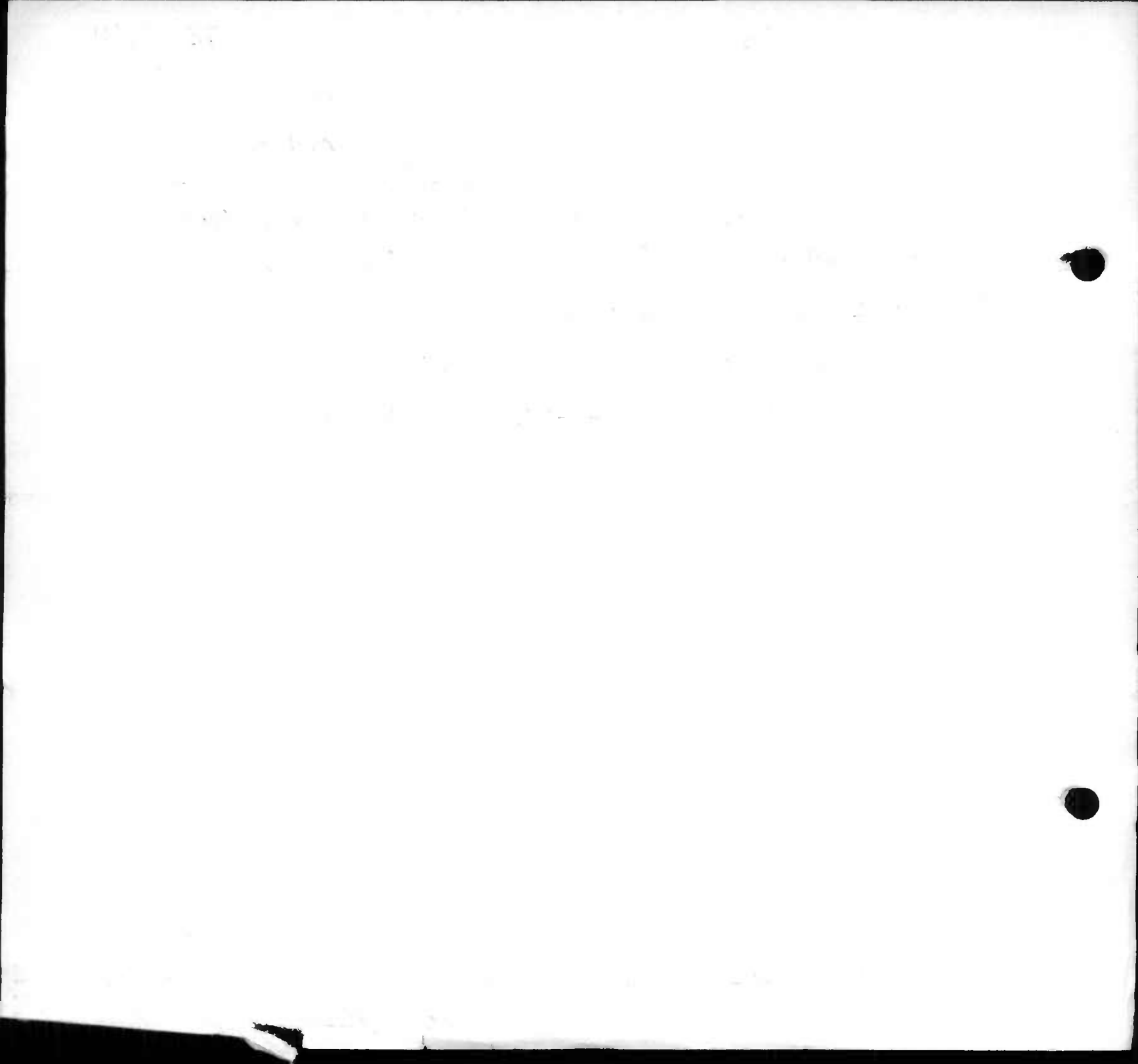




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-340		72 00710		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00710	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Wilbur B. Stahl</u>				2. DATE AND HOUR OF DEATH <u>1-18-72</u> <u>8 PM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>46 LUTHERAN Hosp. y Md.</u>						4. USUAL RESIDENCE (Where deceased lived. If institutions residence before admission) A. STATE <u>Md</u> B. COUNTY <u>Balto.</u> <u>1510</u>			
						C. CITY OR TOWN <u>BAITIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
						E. STREET AND NUMBER <u>3806 FERNHILL AVE</u>			
5. SEX <u>M</u>	6. RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/11/196</u>	9. AGE (In years last birthday) <u>76</u>	If Under 1 Yr. Months Days		If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired-owner</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Chapman Oil Company</u>		11. BIRTHPLACE (State or foreign country) <u>Kansas</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Alex Mathew Stahl</u>				14. MOTHER'S MAIDEN NAME <u>Mattie Bassett</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>yes</u> <u>WWI</u>				16. SOCIAL SECURITY NO. <u>215-32-1413</u>		17. INFORMANT <u>Family records</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE <u>ACUTE CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>INTESTINAL OBSTRUCTION =</u> DUE TO, OR AS A CONSEQUENCE OF: <u>TUMOR OF THE</u> <u>LARGE BOWEL</u> (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
<div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>1/12/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>INTESTINAL OBSTRUCTION</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>1/12/72</u> to <u>1/18/72</u> that (I) (we) last saw the deceased alive on <u>1/18/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>Quincy</u>				23B. DATE SIGNED <u>1/18/72</u>				23C. PHYSICIAN'S NAME (Type) DEGREE	
23D. ADDRESS DEGREE				23E. FUNERAL DIRECTOR ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Cremation</u>		24B. DATE <u>1-19-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Greenmount Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore</u> <u>Maryland</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>John H. Huns</u>					



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>C-514</u> <u>72 00711</u>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 00711</u>	
CERTIFICATE OF DEATH					
1. NAME OF DECEASED <u>Miss</u> (Type or Print) <u>MRS ELSIE CAMPBELL</u>		2. DATE AND HOUR OF DEATH <u>19 Jan 72, 7 AM.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>The Provident Hospital</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>Baltimore</u> <u>1538</u>			
5. SEX <u>F</u>		6. RACE <u>N</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	
8. DATE OF BIRTH <u>12-19-07</u>		9. AGE (In years last birthday) <u>64</u>		10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>xxxReter George A Campbell</u>		14. MOTHER'S MAIDEN NAME <u>Bessie Hall</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>9448 6370</u>		17. INFORMANT (Sister) ADDRESS <u>Mrs Mildred Bailey, 905 N Broadway</u>	
18. <u>174X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Cardiorespiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Carcinoma breast with metastasis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>—</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>18 Jan 1972</u> to <u>19 Jan 1972</u> , that (I) (we) last saw the deceased alive on <u>18 Jan 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>R. Rupak C. Mitra</u>		23B. DATE SIGNED <u>19 Jan 72</u>		23C. PHYSICIAN'S NAME (Type) <u>DR. RUPAK C. MITRA</u>	
23D. ADDRESS <u>The Provident Hospital, Balto.</u>		23E. NAME OF REGISTRAR <u>Robert E. Taylor</u>		23F. FUNERAL DIRECTOR <u>Adolphus Galstead</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/22/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT Calvary C-metr</u>	
24D. LOCATION (City, town, or county) (State) <u>A A County Md</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. FUNERAL DIRECTOR <u>Adolphus Galstead</u>			
25D. ADDRESS <u>1206 W North Ave</u>					

2-15-1972 - Letter from - Provident Hospital, Inc. - (Miss) Sandra Mantell  
Correspondence Clerk

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

J-516		72 00712		BALTIMORE CITY HEALTH DEPARTMENT		72 00712	
BIRTH NO.		CERTIFICATE OF DEATH				REG. NO.	
1. NAME OF DECEASED (Type or Print) <u>Clara Jennifer</u>				2. DATE AND HOUR OF DEATH <u>1/19/72</u> <u>8:40</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Park Hill Nursing Home</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1703</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>4017 Liberty Hgts</u>			
5. SEX <u>F</u>	6. RACE <u>Black</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-8-1882</u>	9. AGE (In years last birthday) <u>89</u>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook-Domestic</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Peter Thompson</u>				14. MOTHER'S MAIDEN NAME <u>unknown</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>214-56-7509</u>		17. INFORMANT <u>Mrs Maggie Thompson</u>		ADDRESS <u>2714 E. Bala St</u>
18. <u>180X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>carcinoma cervix uterus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7 months</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>arteriosclerotic CV disease</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:		<u>several years</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>no</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>7-15-</u> <u>1971</u> to <u>1-10-</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>1-10-</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>E Ellsworth Cook</u>				23B. DATE SIGNED <u>1-20-72</u>		23C. PHYSICIAN'S NAME (Type) <u>E ELLSWORTH COOK M.D.</u>	
23D. ADDRESS <u>2431 MARYLAND AVE. BALTO.. Md. 21218</u>				24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>1/22/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT Calvary Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>A A County Md</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 21 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Talley</u>		25C. FUNERAL DIRECTOR <u>Adolphus Walstead</u>		ADDRESS <u>1206 W North Ave</u>	

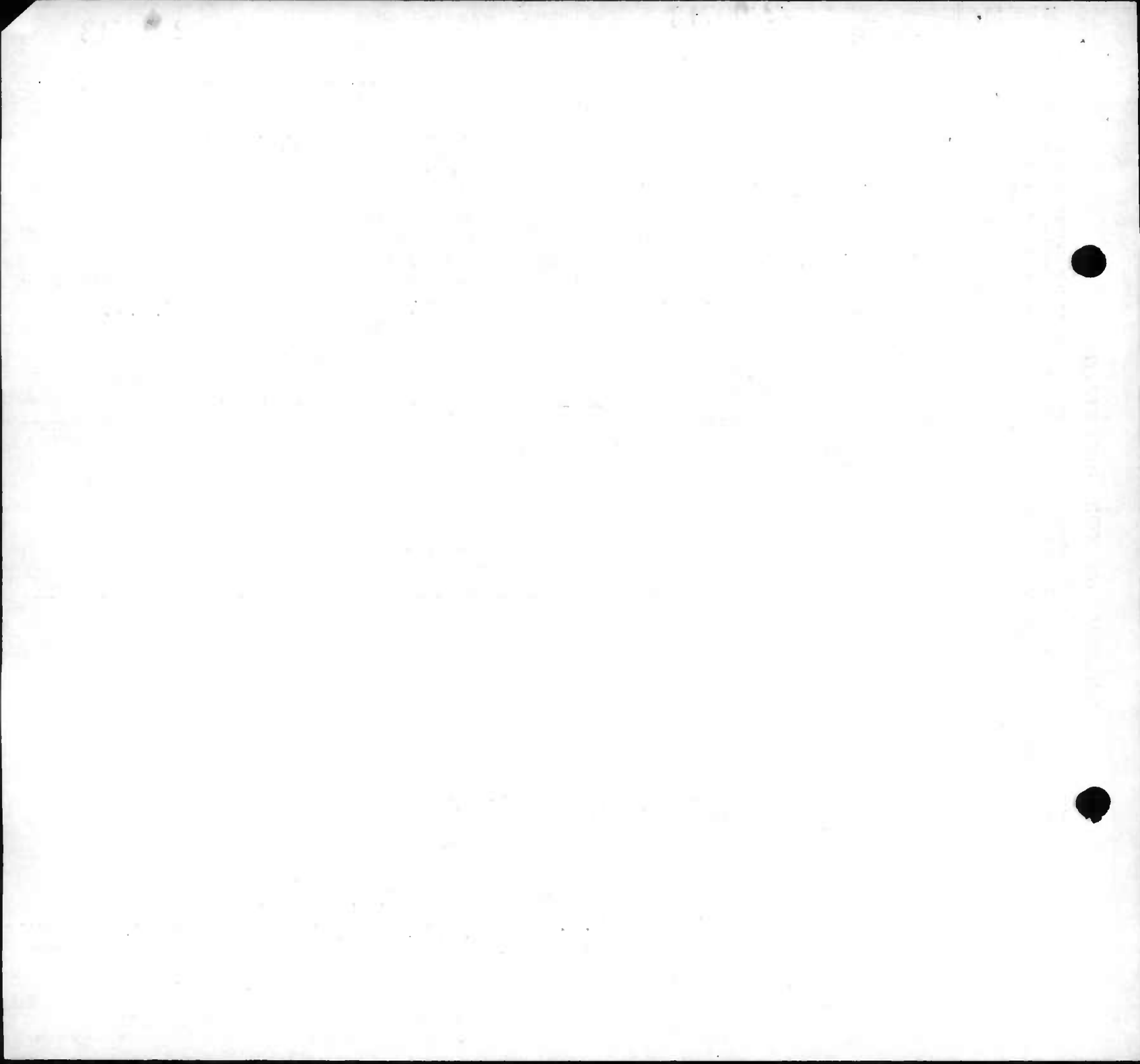
1127 Argyle Ave.

2/26/70 - Adm.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. 72 00713	
BIRTH NO. T-656 72 00713							
1. NAME OF DECEASED (Type or Print) TURNER, EDWIN R				2. DATE AND HOUR OF DEATH JANUARY 20, 1972 2:45P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 ST. AGNES HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 59 Edmondson Ridge			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 01/26/21		9. AGE (In years last birthday) 50	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SALESMAN		10B. KIND OF BUSINESS OR INDUSTRY INSURANCE COMPANY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM TURNER				14. MOTHER'S MAIDEN NAME MARY WELLS TURNER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 219-01-6402		17. INFORMANT ADDRESS ST. AGNES HOSPITAL RECORDS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 412.3 + 1019.0 Cardiac arrhythmia (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). TB R lung lesioned				CAUSE OF DEATH Cardiac arrhythmia (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Old anterolateral myocardial infarction (B) DUE TO, OR AS A CONSEQUENCE OF: ASCVD (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 hrs. 3 yrs.	
19A. DATE OF OPERATION 1		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) YES		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from JANUARY 20 1972 to JANUARY 20 1972 that (I) (we) last saw the deceased alive on JANUARY 20 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE [Signature] DEGREE				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) JOSE APTER M.D.	
23D. ADDRESS BALTIMORE, MD 21229 ST. AGNES HOSPITAL; CATON & WILKENS AVES							
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/72		24C. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1972				25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS Witzke, 1630 Edmondson Avenue 21228	

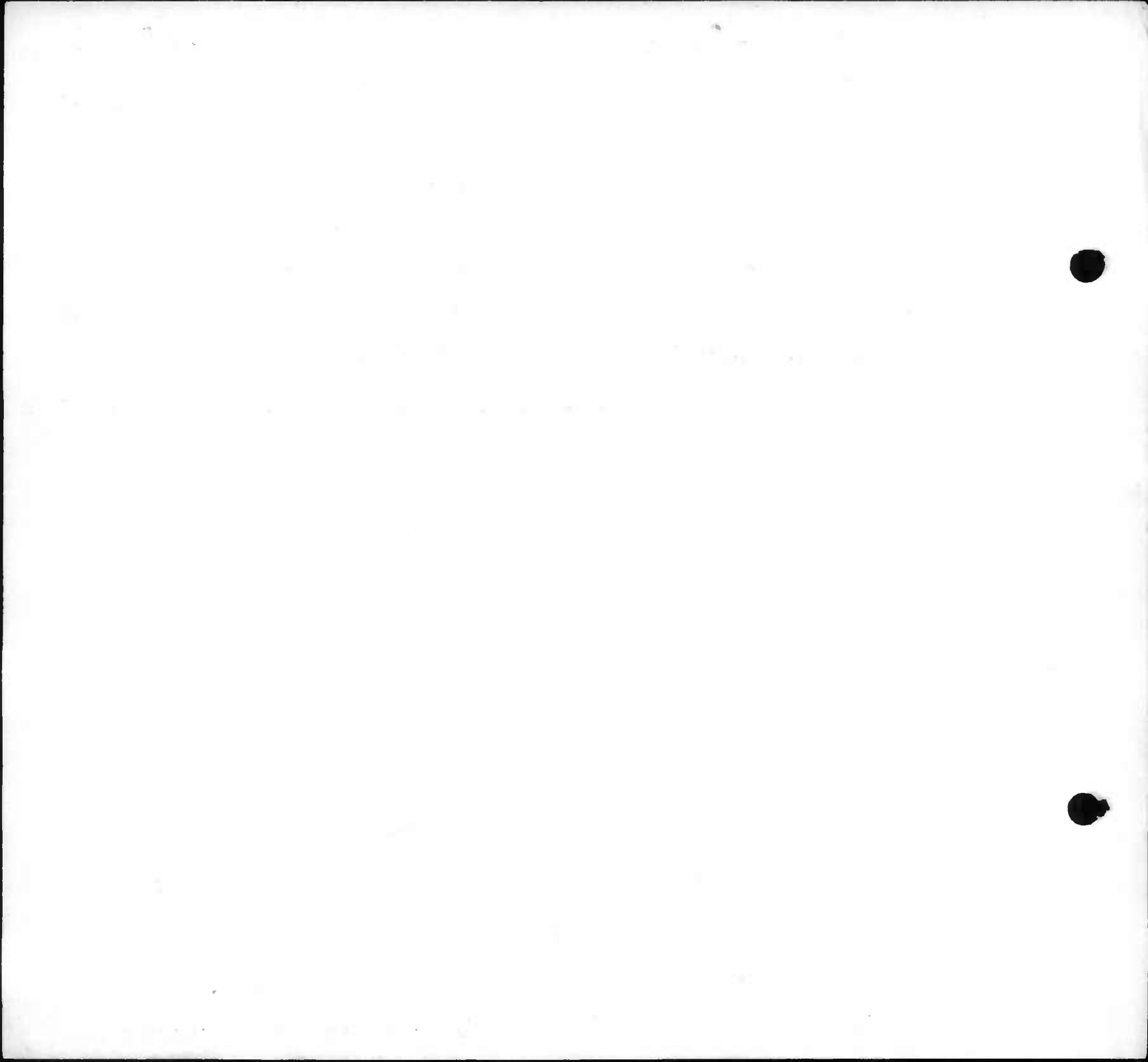




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>R-250</b></span> <span><b>72 00714</b></span> </div>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		<b>REG. NO. 72 00714</b>	
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>James G. Rosson</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>1/21/72 5:35 P.M.</b>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b> <b>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</b> A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b>		<b>5. SEX</b> <b>Male</b> <b>6. RACE</b> <b>White</b> <b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> <b>8. DATE OF BIRTH</b> <b>6-29-83</b> <b>9. AGE (In years last birthday)</b> <b>88</b>			
<b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <b>(If not in hospital or institution, give street address or location)</b> <b>Maryland Gen. Hospital</b>		<b>C. CITY OR TOWN</b> <b>Balt.</b> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>E. STREET AND NUMBER</b> <b>5705 Edmondson Ave.</b>	
<b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>retired</b>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE (State or foreign country)</b> <b>Virginia</b> <b>12. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>13. FATHER'S NAME</b> <b>Late George Rosson</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Mollie Browning</b>			
<b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b> <b>no</b>		<b>16. SOCIAL SECURITY NO.</b> <b>213-05-9641</b>		<b>17. INFORMANT</b> <b>J. Garland Rosson, Jr., 1923 Old Frederick Rd</b> <b>ADDRESS</b>	
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>519.321/85X</b> <b>Chronic obstructive lung disease</b>		<b>CAUSE OF DEATH</b> <b>Chronic obstructive lung disease</b> <b>(A) IMMEDIATE CAUSE</b> <b>Chronic obstructive lung disease</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Chronic obstructive lung disease</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Chronic obstructive lung disease</b> <b>(C)</b>		<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <b>Calycicogenic stenosis</b> <b>Prostatic cancer &amp; skeletal met.</b>					
<b>19A. DATE OF OPERATION</b> <b>2</b> <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY? (Yes or No)</b>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <b>yes</b>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b> <input type="checkbox"/>		<b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b>		<b>21C. WHERE DID INJURY OCCUR?</b> <b>(If in Baltimore City, give exact location)</b>	
<b>21D. TIME OF INJURY (APPROX.)</b> <b>(Month) (Day) (Year) (Hour)</b>		<b>21E. INJURY OCCURRED</b> <b>While At Work</b> <input type="checkbox"/> <b>Not While At Work</b> <input checked="" type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from 1/15/72 to 1/21/72 that (I) (we) last saw the deceased alive on 1/21/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>Michael A. Silverman MD</b> <b>DEGREE</b>		<b>Attending Phys.</b> <input type="checkbox"/> <b>Med. Director</b> <input type="checkbox"/> <b>Staff Phys.</b> <input checked="" type="checkbox"/>		<b>23B. DATE SIGNED</b> <b>1/21/72</b>	
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>Michael A. Silverman MD</b> <b>DEGREE</b>		<b>23D. ADDRESS</b>			
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>1/25/72</b>		<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Woodlawn Cemetery</b>	
		<b>24D. LOCATION (City, town, or county)</b> <b>Baltimore, Md.</b>		<b>(State)</b>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 24 1972</b>		<b>25B. NAME OF REGISTRAR</b> <b>John E. Jakes, M.D.</b>		<b>25C. FUNERAL DIRECTOR</b> <b>W. J. Zke, 1630 Edmondson Ave., 21228</b> <b>ADDRESS</b>	



BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO. 72 00715 REG. NO. 72 00715

1. NAME OF DECEASED (Type or Print) <b>DONALD P. SCHAEFER</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <u>January</u> Day <u>19</u> Year <u>1972</u> Hour <u>1:15</u> P. <u>M.</u>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home &amp; Hospital</b>				3. DATE PRONOUNCED DEAD Month <u>January</u> Day <u>19</u> Year <u>1972</u> Hour <u>1:15</u> P. <u>M.</u>			
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) STATE <u>Maryland</u> B. COUNTY <u>201</u>							
6. SEX <b>Male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>12/24/14</b>		10. AGE (In years lost birthday) <b>57</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>unknown</b>		14. MOTHER'S MAIDEN NAME <b>unknown</b>		15. STREET AND NUMBER <b>14 S. Castle Street</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes 6/27/38-8/10/45</b>				17. SOCIAL SECURITY NO. <b>214-05-8548</b>		18. INFORMANT ADDRESS <b>Mrs. Virginia Schaefer, 14 S. Castle Street</b>	
19. <b>E988X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Subdural hematoma</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>Yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Street</b>		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? <b>1700 Block of Fairmount Ave.</b>			
22D. TIME OF INJURY (APPROX.) <b>1-18-72</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Apparently fell</b>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>  ACTUAL SIGNATURE <u>Charles S. Springate</u> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> <b>January 20, 1972</b>							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>cremation</b>		24B. DATE <b>1/22/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Laudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>2720000713</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Witzke, 1630 Edmondson Avenue 2228</b>			

3-1-1972 - Letter from - Office of the Chief Medical Examiner, Charles S. Springate, M.D.  
Assistant Medical Examiner

HRS

C-636

72 00716

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00716

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>JAMES CARTER</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>33 JOHNS HOPKINS HOSPITAL</b> (If not in hospital or institution, give street address or location)				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 22, 1972 7:15 P.</b> M.			
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>909</b>							
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>2-26-46</b>		10. AGE (In years last birthday) <b>25</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		E. STREET AND NUMBER <b>1321 Wilcox Street</b>			
11. BIRTHPLACE (State or foreign country) <b>Balto. Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>UNKNOWN</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>LABORER</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Sanitation Dept.</b>		15. MOTHER'S MAIDEN NAME <b>IRENE CARTER</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		17. SOCIAL SECURITY NO. <b>218-44-2881</b>		18. INFORMANT <b>JEAN CARTER</b>		ADDRESS <b>1324 Wilcox St.</b>	
19. <b>E965X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <b>Gunshot wound of chest</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED				21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>Alley</b>		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1321 Wilcox Street 909</b>			
22D. TIME OF INJURY (APPROX.) <b>1-22-72 P.M.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Shot during altercation</b>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED: <b>1/23/72</b> EXAMINER'S NAME (Type)							
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-28-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Anne Arundel County, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Caplan &amp; Scruggs</b>		ADDRESS <b>1412 E. Preston</b>	

Document number 35 0018

1931 Wilson Street

Washington, D.C.

United States of America

Printed by the Government Printing Office

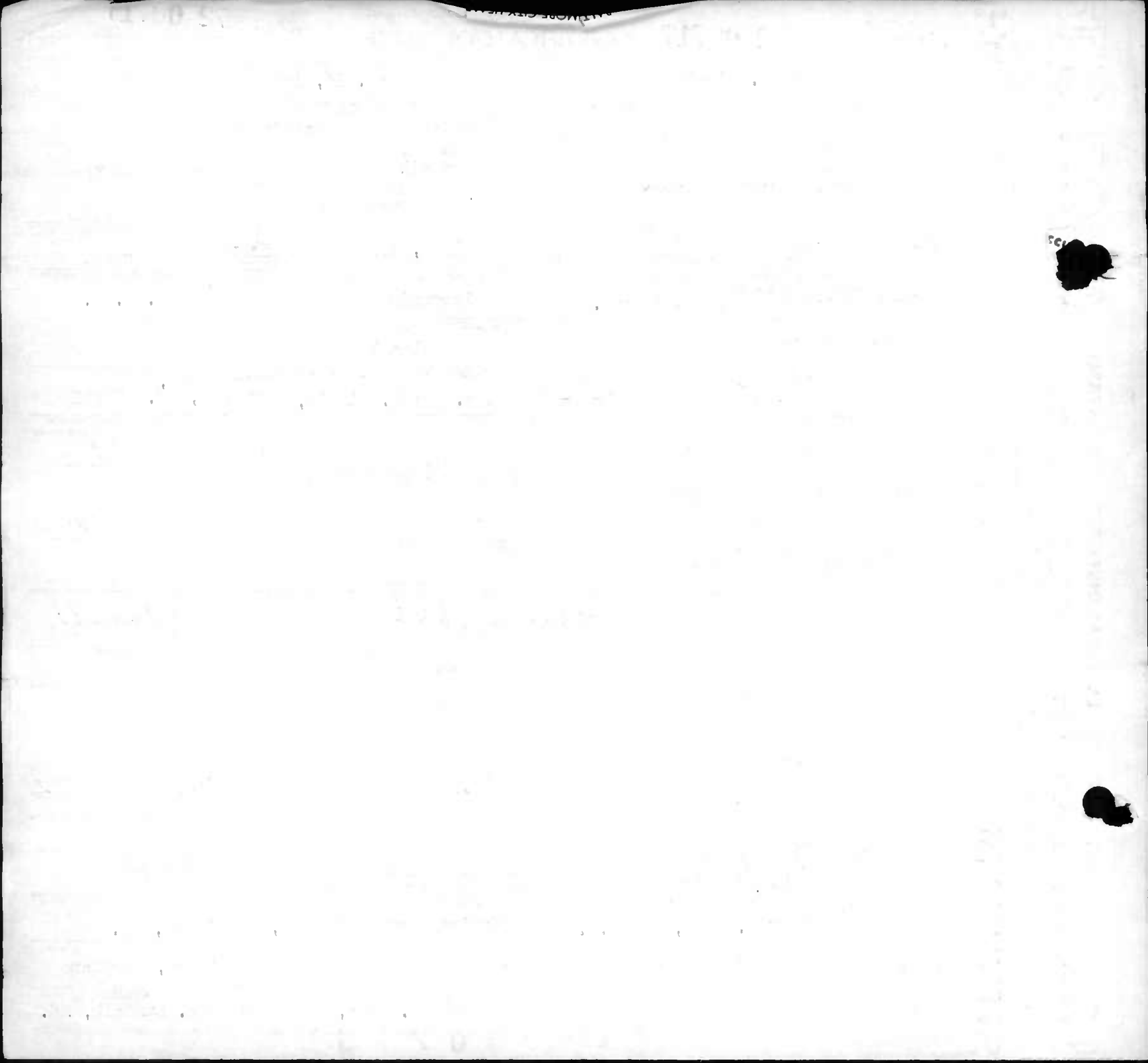
1931

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 00717</span>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="float: right;">72 00717</span>
1. NAME OF DECEASED (Type or Print) <b>Henry F. Virgin</b>		2. DATE AND HOUR OF DEATH <b>Jan. 16, 1972</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>31 Baltimore City Hospital</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>  C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>  E. STREET AND NUMBER <b>3439 Dunran Road</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 8, 1913</b>	9. AGE (In years last birthday) <b>58</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Chemical Operator</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>F M C Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Wisconsin</b>
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>Henry Virgin</b>		
14. MOTHER'S MAIDEN NAME <b>Alma ?</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes WWII</b>		
16. SOCIAL SECURITY NO. <b>397-03-2707</b>		17. INFORMANT (Wife) <b>3439 Dunran Road, Mrs. Ida E. Virgin, Dundalk, Md. 21222</b>		
18. <b>410.91</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF:  <b>ASHD</b> (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) <b>Thrombolytic</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  <b>sudden</b>  <b>5 years</b>  <b>1 month</b>
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION <b>1/15/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (1) (this hospital) attended the deceased from <b>Jan 10</b> to <b>Jan 15</b> 19 <b>72</b> and that (2) (we) last saw the deceased alive on <b>1/15</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>Robert I. Levy</b>		23B. DATE SIGNED <b>1/18/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Robert I. Levy, M.D.</b>
23D. ADDRESS <b>Medical Arts Building, Baltimore, Md.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		
24B. DATE <b>1/20/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>John J. Duda</b>		25C. FUNERAL DIRECTOR ADDRESS <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>







## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO.	
H-200 72-00718		CERTIFICATE OF DEATH		72 00718	
1. NAME OF DECEASED (Type or Print) Robert D. Haase		2. DATE AND HOUR OF DEATH 1/17/72 7:00 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE Maryland B. COUNTY Baltimore C. CITY OR TOWN Dundalk D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER 9 NORTH SHIP RD 21222			
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 90 7-12-71	9. AGE (In years last birthday) 81	10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret. Crane Operator		10B. KIND OF BUSINESS OR INDUSTRY Beth. Shipyard		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Ferdinand Haase		14. MOTHER'S MAIDEN NAME Alice A. Ash			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) None		16. SOCIAL SECURITY NO. 213-07-5994		17. INFORMANT ADDRESS Records: BCH-4940 Eastern Ave. 21224	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF: (B) FRACTURED HIP DUE TO, OR AS A CONSEQUENCE OF: (C) CHRONIC OBSTRUCTIVE LUNG DISEASE		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days 2 wts	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION 3/12/71		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED FRACTURED HIP		20A. AUTOPSY? (Yes or No) Yes	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) Home		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 9 North Ship Rd 53-00	
21D. TIME OF INJURY (APPROX.) 12 22 71 11:30 PM		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? Fell from Bed	
22. I certify that (I) (this hospital) attended the deceased from 12/16/71 to 1/17/72 that (I) (we) last saw the deceased alive on 1/17/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Michael D Sussman, M.D.		23B. DATE SIGNED 1/17/72		23C. PHYSICIAN'S NAME (Type) Michael D Sussman M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-21-72		24C. NAME OF CEMETERY OR CREMATORY Oak Lawn Cemetery	
24D. LOCATION Baltimore, Maryland		25A. DATE REC'D BY HEALTH DEPT. JAN 24 1972			
25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR ADDRESS 922 Wise Ave. Dundalk, Md. 21222			

2-14-1972 - Letter from - Baltimore City Hospitals - (Mrs.) Helen Fisher  
Supervisor, Information Center

HRS

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00719

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>E. GLEN BURTON</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If not in hospital or institution, give street address or location) <b>31 Baltimore City Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 16 1972 10:20a M.</b>	
6. SEX <b>male</b>		7. RACE <b>white</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Dundalk Balto.</b>	
9. DATE OF BIRTH <b>Oct. 29, 1951</b>		10. AGE (In years last birthday) <b>20</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF <b>U. S. A.</b>	
13. FATHER'S NAME <b>Robert Burton</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Maddie Gillespie</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO. <b>217-56-5949</b>		18. INFORMANT <b>8111 Murray Point Road (Father)</b> <b>Mr. Robert Burton, Dundalk, Md. 21222</b>	
19. <b>571.0 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Fatty alteration of liver</b>		CAUSE OF DEATH <b>Acute alcoholic intoxication</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		DATE SIGNED <b>1-17-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/20/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>Robert S. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>John J. Duda, 7922 Wise Ave. Dundalk, Md.</b>		ADDRESS	

2-17-1972 - Completion of cause of death on a pending medical examiner death certificate  
Russell S. Fisher, M.D.

HRS

REG. NO.

72 00720

BIRTH NO.

1. NAME OF DECEASED (Type or Print) M. Ruth Michael		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 17 72 8:21 A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 17 72 8:21 A. M.	
6. SEX Female		7. RACE White	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Sparrows Point Baltimore	
9. DATE OF BIRTH 8-9-08		10. AGE (In years last birthday) 63	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Robert L. Smallwood		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY Baltimore 530	
15. MOTHER'S MAIDEN NAME Pearl L. Bradfield		16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
17. SOCIAL SECURITY NO. 217-56-5190		18. INFORMANT Daughter: Miss Mildred Michael Md. 21219	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) Yes		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23.	
I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D.		Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-18-72	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE Jan. 20, 1972	
24C. NAME OF CEMETERY or CREMATORY Gardens of Faith		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1972		25B. NAME OF REGISTRAR E. J. ...	
25C. FUNERAL DIRECTOR John J. Duda 7922 Wise Ave. Dundalk, Md.		ADDRESS	

NO. 1000

STATE OF TEXAS

COUNTY OF DALLAS

IN SENATE, FEBRUARY 1, 1900.

1900

REPORT OF THE COMMISSIONER OF THE LAND OFFICE.

FOR THE YEAR ENDING DECEMBER 31, 1899.

COMMISSIONER OF THE LAND OFFICE.

REPORT OF THE

COMMISSIONER OF THE

LAND OFFICE, FOR THE YEAR ENDING DECEMBER 31, 1899.

REPORT OF THE COMMISSIONER OF THE LAND OFFICE.

FOR THE YEAR ENDING DECEMBER 31, 1899.

REPORT OF THE

1900

REPORT OF THE COMMISSIONER OF THE LAND OFFICE.

FOR THE YEAR ENDING DECEMBER 31, 1899.

REPORT OF THE COMMISSIONER OF THE LAND OFFICE.

FOR THE YEAR ENDING DECEMBER 31, 1899.

REPORT OF THE COMMISSIONER OF THE LAND OFFICE.

FOR THE YEAR ENDING DECEMBER 31, 1899.

REPORT OF THE COMMISSIONER OF THE LAND OFFICE.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <b>72 00721</b>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <b>PATUCAS, PETER C</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>JANUARY 18, 1972</b> <b>1:00P</b> M.		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> <b>ST. AGNES HOSPITAL</b>		<b>4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission)</b> A. STATE <b>MARYLAND</b> B. COUNTY <b>2008</b>		
<b>5. SEX</b> <b>MALE</b>		<b>6. RACE</b> <b>CAUCASIAN</b>		
<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>06/15/91</b>		
<b>9. AGE (In years last birthday)</b> <b>80</b>		<b>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b> <b>RESTAURANTEUR</b>		
<b>11. BIRTHPLACE (State or foreign country)</b> <b>GREECE</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		
<b>13. FATHER'S NAME</b> <b>CHARLES PATOUHAS</b>		<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>		
<b>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</b> <b>NONE</b>		<b>16. SOCIAL SECURITY NO.</b> <b>228-18-4595</b>		
<b>17. INFORMANT</b> <b>ST. AGNES HOSPITAL RECORDS</b>		<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> <b>Emphysema</b>		
<b>19A. DATE OF OPERATION</b> <b>1/18/72</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>Pneumonia and Cachexia</b>		
<b>20A. AUTOPSY? (Yes or No)</b> <b>NO</b>		<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> <b>NO</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Indicate medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b> <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
<b>21F. HOW DID INJURY OCCUR?</b>		<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>JANUARY 17</b> <b>19 72</b> <b>to</b> <b>JANUARY 18</b> <b>19 72</b> <b>that (I) (we) last saw the deceased alive on</b> <b>JANUARY 18</b> <b>19 72</b> <b>and that (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>		
<b>23A. SIGNATURE</b> <b>Rahman Karimi M.D.</b>		<b>23B. DATE SIGNED</b> <b>1/18/72</b>		
<b>23C. PHYSICIAN'S NAME (Type)</b> <b>RAHMAN KARIMI M.D.</b>		<b>23D. ADDRESS</b> <b>BALTO, MD 21229</b> <b>ST. AGNES HOSPITAL; CATON &amp; WILKENS AVES.</b>		
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>24B. DATE</b> <b>1/21/1972</b>		
<b>24C. NAME of CEMETERY or CREMATORY</b> <b>Mt. Mariah Cemetery</b>		<b>24D. LOCATION</b> (City, town, or county) (State) <b>Towson, Maryland</b>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 24 1972</b>		<b>25B. NAME OF REGISTRAR</b> <b>G. Truman Schwab</b>		
<b>25C. FUNERAL DIRECTOR</b> <b>G. Truman Schwab</b>		<b>ADDRESS</b> <b>3512 Frederick Ave.</b>		

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST

15:00 ST



7-512		72 00722		BALTIMORE CITY HEALTH DEPARTMENT		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 72 00722	
BIRTH NO.									
1. NAME OF DECEASED (Type or Print) <b>ANDREW CHARLES FAMBACK Jr.</b>					2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 19, 1972</b>				
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>00 4009 Liberty Heights</b>					3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 19, 1972 4:00 P.M.</b>				
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1510</b>									
6. SEX <b>Male</b>		7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>7/19/1903</b>		10. AGE (In years last birthday) <b>#68</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		E. STREET AND NUMBER <b>4009 Liberty Heights</b>	
13. FATHER'S NAME <b>Andrew C. Famback Sr.</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Riuteman</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Freight</b>		15. MOTHER'S MAIDEN NAME <b>Mary Hettinger</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>714 05 6633</b>		18. INFORMANT <b>Joseph F. Famback</b>		ADDRESS <b>Rockhill Beach</b>			
19. <b>162.1</b>		CAUSE OF DEATH <b>Pasadena, Md.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Carcinoma of lung and mouth</b> DUE TO, OR AS A CONSEQUENCE OF:							
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) _____ DUE TO, OR AS A CONSEQUENCE OF:							
(C) _____									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).									
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>No</b>					
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?					
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?					
23.		I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Springate</b>		EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>January 20, 1972</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Glen Haven Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Glen Burnie, Md.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fink, M.D.</b>		25C. FUNERAL DIRECTOR <b>Raymond C. Fink</b>		ADDRESS <b>Glen Burnie, Md.</b>			

35 0075

35 0075

WILSON & WILSON, INC. 1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

WILSON & WILSON, INC.

1000

1000

1000

1000

1000

B-400

72 00723 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00723

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Lucille Bailey		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 18 Year 72 Hour 5:15 A.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 40 E. Montgomery Street		3. DATE PRONOUNCED DEAD Month 1 Day 18 Year 72 Hour 5:15 A.M.	
6. SEX Female		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Aug 8, 1925		10. AGE (In years last birthday) 47	
11. BIRTHPLACE (State or foreign country) North Carolina		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Factory worker		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME Jessie Smith		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No	
17. SOCIAL SECURITY NO. unknown		18. INFORMANT ADDRESS Rodger Bailey-2077 Druid Park Dr. 21211	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) Fatty metamorphosis of liver ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 1-18-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Removal		24B. DATE 1/21/72	
24C. NAME OF CEMETERY or CREMATORY Harrelson Funeral Home		24D. LOCATION (City, town, or county) (State) Henrietta, North Carolina	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1972		25B. NAME OF REGISTRAR Robert E. Bailey, M.D.	
25C. FUNERAL DIRECTOR ADDRESS Donovan Funeral Home 3818 Roland Ave			

35 00757

35 00757

000

35 00757

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-232		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00724	
72 00724		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>GAJDOSIK Louise</u>		2. DATE AND HOUR OF DEATH <u>1/18/72 7:30pm</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>HOUSE IN THE PINES Bel Air</u> <u>5839 Belaire Road</u> <u>BALTIMORE Maryland</u>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>Balto.</u> C. CITY OR TOWN <u>Linover</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>7402 Brookwood Avenue</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/9/1882</u>	9. AGE (In years last birthday) <u>89</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>		11. BIRTHPLACE (State or foreign country) <u>Czechoslovakia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>Czechoslovakia</u>		13. FATHER'S NAME <u>Antonio Sandrick</u>			
14. MOTHER'S MAIDEN NAME <u>Unknown</u>		15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>216-03-4351</u>		17. INFORMANT ADDRESS <u>Leo Gajdosik 7402 Brookwood Rd. Balto. 21236</u>			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>412.4 I</u> <u>CHRONIC EVD</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>CHRONIC EVD</u> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yr</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>16 Oct</u> 19 <u>48</u> to <u>18 Jan</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>12 Jan</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Howard Goodman</u>		23B. DATE SIGNED <u>20 Jan 72</u>		23C. PHYSICIAN'S NAME (Type) <u>Howard Goodman, M.D.</u>	
23D. ADDRESS <u>6604 Highland Rd Balto Md 21234</u>		24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>			
24B. DATE <u>1/21/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Cedar Hill Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Ritchie Hwy. Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1972</u>		25B. NAME OF REGISTRAR <u>Blaise J. ...</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Looseleaf Funeral Home 7401 Belair Rd. Balto.</u>	

15700 ST

15700 ST

417,000,000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 00725</b>	
B-650 72 00725				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>ROBERT GORDON BYRON</b>		2. DATE AND HOUR OF DEATH <b>1/20/72 500 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIVERSITY OF MD. HOSPITAL 38</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>1803</b>			
		C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
		E. STREET AND NUMBER <b>1146 W. LOMBARD ST. 21223</b>			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7/30/03</b>	9. AGE (In years last birthday) <b>68</b>	10. If Under 1 Yr. Months Days If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>FACTORY WORKER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SHIPBUILDING CHEMICAL PLANT</b>		11. BIRTHPLACE (State or foreign country) <b>MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>NICHOLAS BYRON</b>		14. MOTHER'S MAIDEN NAME <b>MAUDE SMITH</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>218-01-7463</b>		17. INFORMANT <b>Marie E. Byron 1146 West Lombard St. 21223</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>492X + 472X</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>ACUTE RESPIRATORY FAILURE</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>COPD (EMPHYSEMA) + CHF</b>		<b>8 years</b>	
		(C) <b>INFLUENZA</b>		<b>6 days</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>COP PULMONALE</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/15/72</b> 19__ to <b>1/20/72</b> 19__ that (I) (we) last saw the deceased alive on <b>1/20/72</b> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Lawrence A. Fleming MD</b>		23B. DATE SIGNED <b>1/20/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>LAWRENCE A. FLEMING MD</b>		23D. ADDRESS <b>UNIVERSITY OF MD HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/24/72</b>	24C. NAME OF CEMETERY or CREMATORY <b>Meadowridge Mem. Park</b>		24D. LOCATION (City, town, or county) (State) <b>Howard County, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>Robert F. Taylor, MD.</b>		25C. FUNERAL DIRECTOR <b>Walters Funeral Home Pratt &amp; Stricker</b>	
				ADDRESS <b>Streets 21223</b>	

STUDY ST

STUDY ST





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

YS 150-REV. 1/1/68

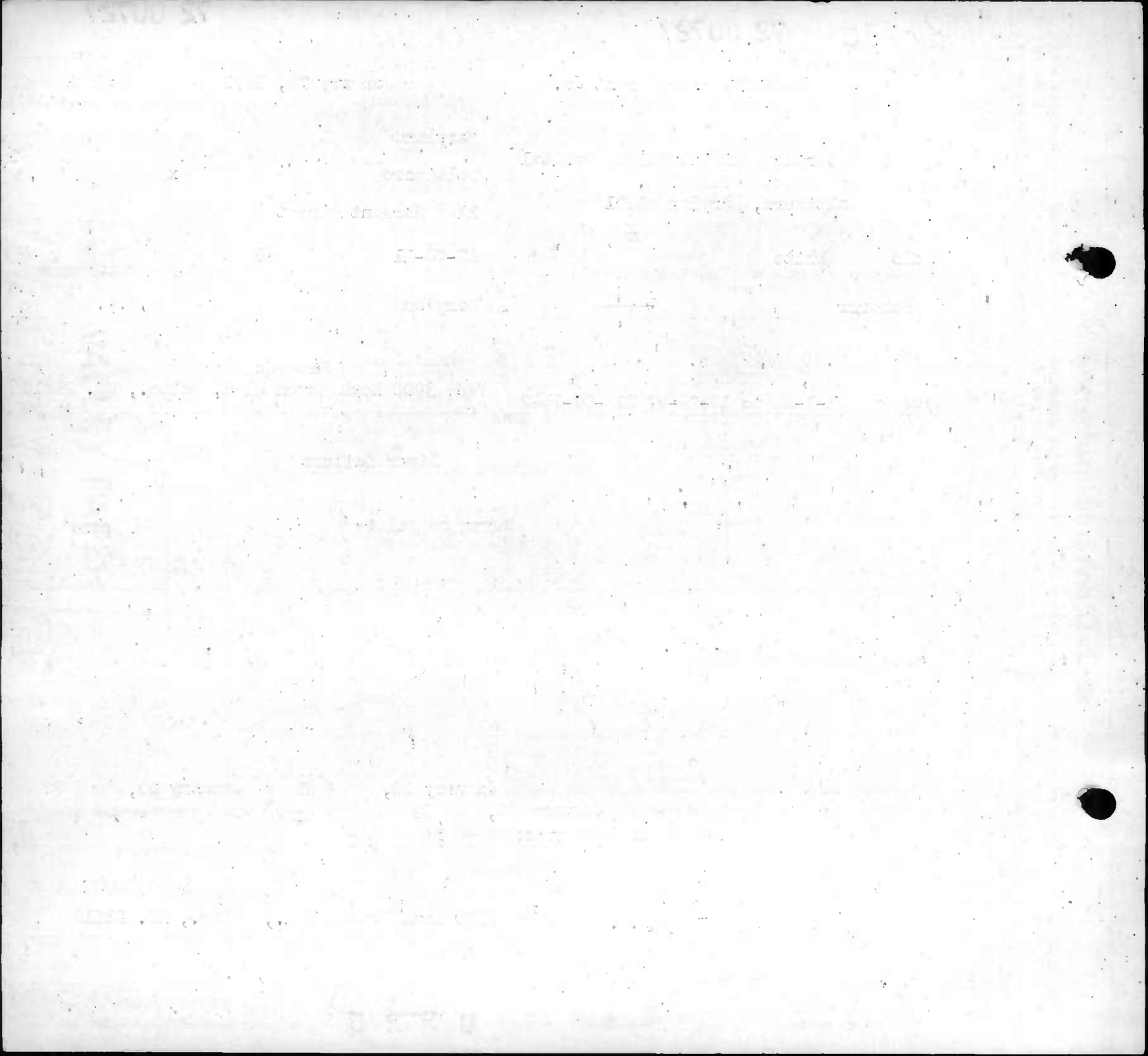
05700 ST

05700 ST

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-230 72 00727		BALTIMORE CITY HEALTH DEPARTMENT		72 00727	
BIRTH NO.		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>BUCKHEIT, Henry Grant Sr.</b>			2. DATE AND HOUR OF DEATH <b>January 20, 1972 4:25 A M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Blvd.</b> <b>Baltimore, Maryland 21218</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2102</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1128 Sergeant Street</b>		
5. SEX <b>Male</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-26-11</b>	9. AGE (In years last birthday) <b>60</b>	If Under 1 Yr. Months: Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>			10B. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Henry G. Buckheit Sr.</b>		
14. MOTHER'S MAIDEN NAME <b>Jennie Shears</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1-3-44 to 10-28-47</b>		
16. SOCIAL SECURITY NO. <b>216-07-7642</b>			17. INFORMANT <b>Records</b> ADDRESS <b>VAH, 3900 Loch Raven Blvd. Balto., Md. 21218</b>		
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>Liver failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Serum hepatitis</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>25 years</b>		
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>NO</b>		
20A. AUTOPSY? (Yes or No) <b>NO</b>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>00-00</b>		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>January 10, 1972</b> to <b>January 20, 1972</b> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>January 20, 1972</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) did <input checked="" type="checkbox"/> view the body after death.					
23A. SIGNATURE <b>David Posner</b>			23B. DATE SIGNED <b>1/20/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>DAVID POSNER, M.D.</b>			23D. ADDRESS <b>3900 Loch Raven Blvd., Balto., Md. 21218</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			24B. DATE <b>1-24-72</b>		
24C. NAME OF CEMETERY or CREMATORY <b>Glen Haven Cemetery</b>			24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>		
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>			25B. NAME OF REGISTRAR <b>McGulley Funeral Home</b>		
25C. FUNERAL DIRECTOR <b>McGulley Funeral Home</b>			ADDRESS <b>130 E. Fort Ave.</b>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

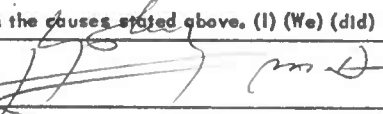
C-246		72 00728		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		X		REG. NO. 72 00728	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <i>CIGLAR, Stephen</i>		2. DATE AND HOUR OF DEATH <i>1/18/72</i>		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>Baltimore</i>		5. SEX <i>Male</i> 6. RACE <i>Caucasian</i>	
FULL NAME OF HOSPITAL OR INSTITUTION <i>Baltimore City Hosp</i>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>4940 Eastern Avenue 21224</i>		C. CITY OR TOWN <i>Baltimore</i>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER <i>1614 Rickenbacker Rd 21221</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Bookkeeper</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Cities Service Co.</i>		8. DATE OF BIRTH <i>7-20-03</i>		9. AGE (In years last birthday) <i>68</i>		If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		11. BIRTHPLACE (State or foreign country) <i>Penna.</i>	
13. FATHER'S NAME <i>Michael Ciglar</i>		14. MOTHER'S MAIDEN NAME <i>Mary Tomasko</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>198 05 1609</i>		17. INFORMANT <i>Elizabeth Conahan</i>		ADDRESS <i>1716 Earhardt Rd. Balto 21221</i>	
18. <i>436.9 I</i>		CAUSE OF DEATH		DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Respiratory Arrest</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>20 min</i>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(B) <i>CVA</i> DUE TO, OR AS A CONSEQUENCE OF:				(C) <i>2 days</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				<i>ASCVS, S/P 3 MI'S</i>							
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>NO</i>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <i>28 Jan</i> 19 <i>72</i> to <i>18 Jan</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>18 Jan</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
23A. SIGNATURE <i>S. S. Nightingale MD</i>		23B. DATE SIGNED <i>1/18/72</i>		23C. PHYSICIAN'S NAME (Type) <i>S. S. NIGHTINGALE</i>		23D. ADDRESS <i>BCH 4940 Eastern Avenue 21224</i>					
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/21/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Holly Hill Memorial Gardens</i>		24D. LOCATION (City, town, or county) (State) <i>Baltimore Co., Md.</i>					
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 24 1972</i>		25B. NAME OF REGISTRAR <i>James E. [illegible]</i>		25C. FUNERAL DIRECTOR <i>Bozowski</i>		ADDRESS <i>Bozowski Funeral Home 1407 Eastern Ave.</i>					

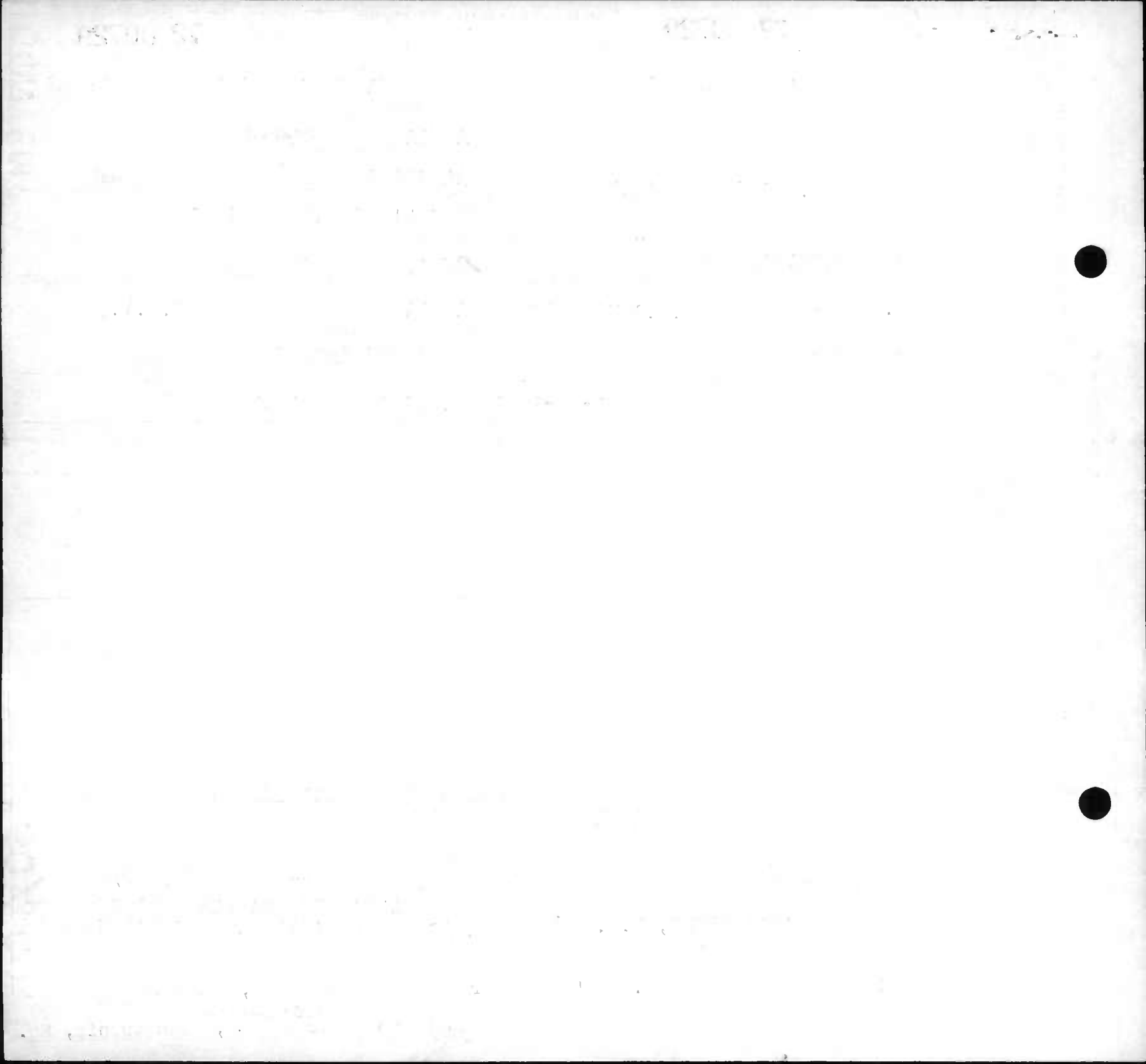
STON ST

STON ST

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 00729</b>	
H-200 72 00729		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <b>WICKS, MARY E</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 20, 1972 1:00P</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 ST. AGNES HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>Howard</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>6945 LINDEN AVE 21227</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>03/21/09</b>		9. AGE (In years lost birthday) <b>62</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dept. of Defence</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U.S. GOVERNMENT</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>CHARLES ENSOR</b>			
14. MOTHER'S MAIDEN NAME <b>FLORENCE (DEBOE) ENSOR</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NONE None</b>			
16. SOCIAL SECURITY NO. <b>223-20-1401</b>		17. INFORMANT ADDRESS <b>ST. AGNES HOSPITAL RECORDS</b>			
18. <b>470.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardiac arrhythmia</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Extensive interstitial myocardial inf. acute</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 hr</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>ASCVD</b>		(C) _____	
<b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>JANUARY 15</b> 19 <b>72</b> to <b>JANUARY 20</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>JANUARY 20</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE 		23B. DATE SIGNED <b>1/20/72</b>		23C. PHYSICIAN'S NAME (Type) <b>JOSE APTER, M.D.</b>	
23D. ADDRESS <b>BALTIMORE, MARYLAND 21229</b>		23E. FUNERAL DIRECTOR <b>AB Wilson</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>St. Ann's Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>			
25B. NAME OF REGISTRAR <b>John S. Taylor, M.D.</b>		25C. FUNERAL HOME <b>Singleton Funeral Home, Glen Burnie, Md.</b>			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">72 00730</span>	
7-452		72 00730		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print)		DOROTHY FELLING		2. DATE AND HOUR OF DEATH January 18, 1972	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		A. STATE B. COUNTY	
40 St. Agnes Hospital				Maryland Anne Arundel	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Glen Burnie		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
		606 Tranton Road			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
Female	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	August 2, 07	64	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Housewife		Own Home		Maryland	
13. FATHER'S NAME			12. CITIZEN OF WHAT COUNTRY?		
Christian H. Schreiver			USA		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT
No None			215/18/7114		Mr. Howard E. Felling (husband) #4
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			CAUSE OF DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			(A) IMMEDIATE CAUSE		
ANTECEDENT CAUSES			DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			DUE TO, OR AS A CONSEQUENCE OF:		
II			DUE TO, OR AS A CONSEQUENCE OF:		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			DUE TO, OR AS A CONSEQUENCE OF:		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1967 to 1-17-72 that (I) (we) last saw the deceased alive on 1-18-72 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
Wayne B. Tate			1/20/72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
			Central Ave., Glen Burnie, Md.		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		1/22/72		Glen Haven Memorial Park	
				Glen Burnie, AA Md.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 24 1972		Robert E. Taylor, R.D.		Singleton Funeral Home, Glen Burnie, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 00731
amend item 1 per court order 8-29-13 vt		
<b>CERTIFICATE OF DEATH AMENDED BY COURT ORDER</b>		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH
MARANTO, Samuel Salvatore		1-21-1972 12.45 P.M.
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE B. COUNTY
UNION MEMORIAL HOSPITAL 44		Maryland 2706
5. SEX M 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN D. INSIDE CITY LIMITS?
		BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
8. DATE OF BIRTH 9-31-1908		E. STREET AND NUMBER 5424 Harford Rd
9. AGE (In years last birthday) 80		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)
RETIRED		ITALY
10B. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY?
		AMERICAN
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME
VINCENT MARANTO		Anna ?
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.
No		217-32-9090
17. INFORMANT		ADDRESS
Mr Vincent R Maranto		3024 Woodring
18. CAUSE OF DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		
ANTECEDENT CAUSES		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Pneumonia - CVA		
(B) DUE TO, OR AS A CONSEQUENCE OF: CVA		
(C)		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1-09-72 to 1-21-72 that (I) (we) last saw the deceased alive on 1-21-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		
23A. SIGNATURE		23B. DATE SIGNED
[Signature] M.D. DEGREE		1-21-1972
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS
GHASSAN NAHAS		UNION MEMORIAL HOSPITAL, Balto-Md
24A. BURIAL CREMATION, REMOVAL (Specify)	24B. DATE	24C. NAME of CEMETERY or CREMATORY
Burial	1/24/72	Holy Redeemer
24D. LOCATION (City, town, or county) (State)		
Baltimore, Maryland		
25A. DATE REC'D BY HEALTH DEPT.	25B. NAME OF REGISTRAR	25C. FUNERAL DIRECTOR
JAN 24 1972	[Signature]	ADDRESS
Leonard J. Ruck Inc. Baltimore, Md		

C2108  
181/2/21/5/20

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

0-161		72 00732		BALTIMORE CITY HEALTH DEPARTMENT		72 00732	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>RAY OVERBECK</b>				2. DATE AND HOUR OF DEATH <b>1/20/72 3:30a M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL OF BALTIMORE</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2402 HUNT DRIVE 21209</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/13/87</b>	9. AGE (In years last birthday) <b>84</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JACOB SNITZ</b>				14. MOTHER'S MAIDEN NAME <b>SARAH ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT <b>MR. HAROLD OVERBECK, 7902 WINTERSET AVE. #21208</b>			
18. <b>486X I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>PNEUMONIA.</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b>			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <b>1/17/72</b> to <b>1/20/72</b> that (2) (we) last saw the deceased alive on <b>1/20/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (3) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Thymer MA</b>				23B. DATE SIGNED <b>1/20/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>B. KERZNER MA</b>				23D. ADDRESS <b>SINAI HOSPITAL</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-20-72</b>		24C. NAME of CEMETERY or CREMATORY <b>LUBAWITZ NUSACH ARI</b>		24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>Robert J. ...</b>		25C. FUNERAL DIRECTOR <b>SOUL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

58702 ST

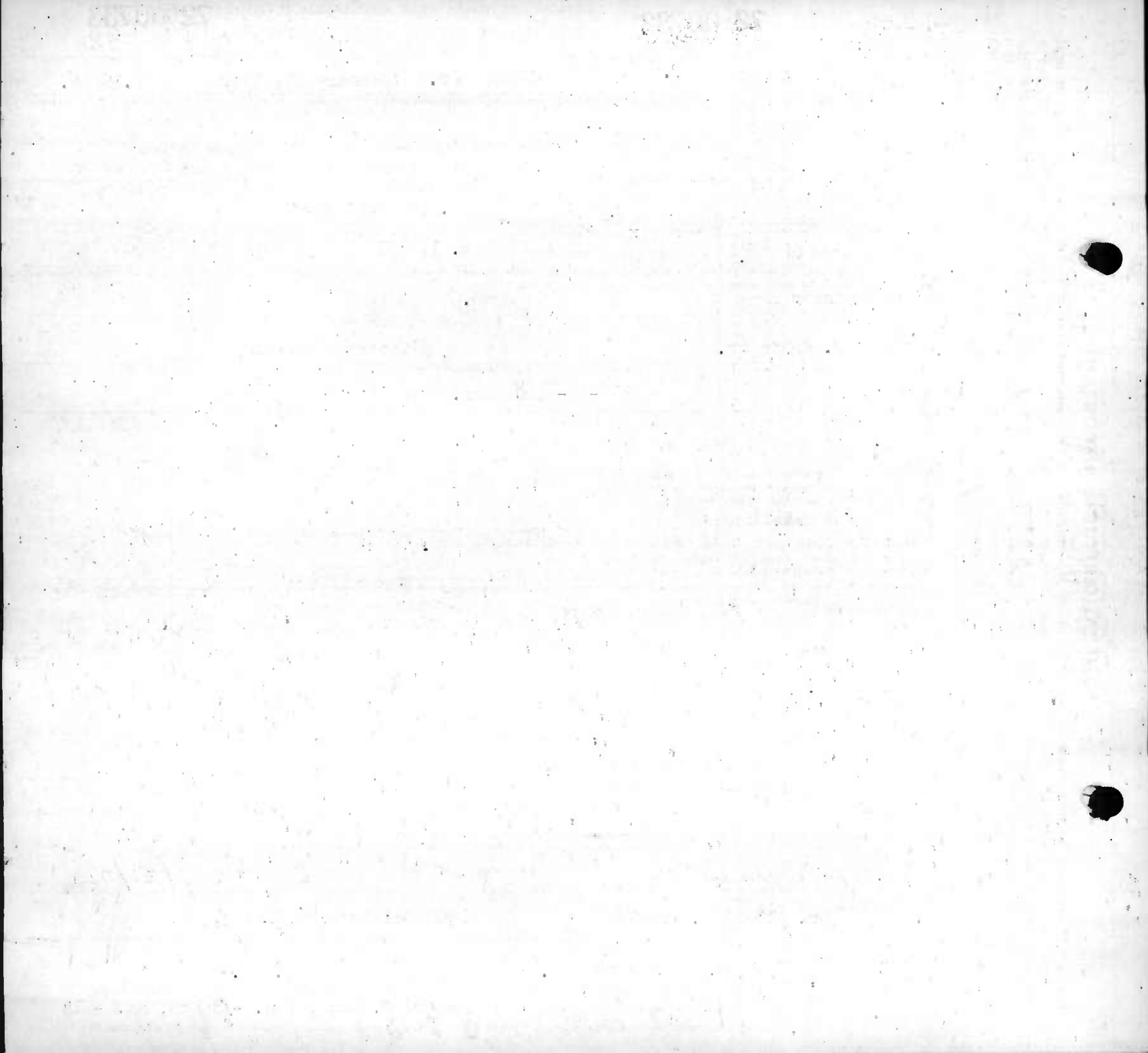
58702 ST



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">1-520</span>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">72 00733</span>	
72 00733			CERTIFICATE OF DEATH		
1. NAME OF DECEASED (Type or Print)		URIAH P. JONES Jr.		2. DATE AND HOUR OF DEATH January 21, 1972 2.15 A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  90 HOUSE IN THE PINES BELAIRE			A. STATE Md B. COUNTY 601		
5. SEX male		6. RACE white	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 1, 1891
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Marine Engineer		10B. KIND OF BUSINESS OR INDUSTRY		9. AGE (In years last birthday) 80	11. BIRTHPLACE (State or foreign country) Md.
13. FATHER'S NAME Uriah P. Jones Sr.			14. MOTHER'S MAIDEN NAME Elizabeth Donohue		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 217-14-6860		17. INFORMANT Mrs. Rosa lie Jones same	
18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>Arteriosclerotic Heart Disease</i> (B) <i>Generalized Arteriosclerosis</i> (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A): <i>Diarrhea; Fibrosis; Peripheral Vascular Disease</i>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH -		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <i>11/21/1971</i> to <i>1/21/1972</i> , that (I) ( <del>we</del> ) last saw the deceased alive on <i>1/20/1972</i> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.					
23A. SIGNATURE <i>Albert B. Bradley</i>				23B. DATE SIGNED <i>1/21/72</i>	
23C. PHYSICIAN'S NAME (Type) Dr. Albert B. Bradley				23D. ADDRESS 4900 Belair Road, Balto, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/72		24C. NAME OF CEMETERY or CREMATORY Oak Lawn Cem.	
24D. LOCATION (City, town, or county) (State) Balto. Md.					
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1972		25B. NAME OF REGISTRAR <i>Robert C. Bradley</i>		25C. FUNERAL DIRECTOR Leonard J. Ruck, Inc. - Bal to, Md. - 14	

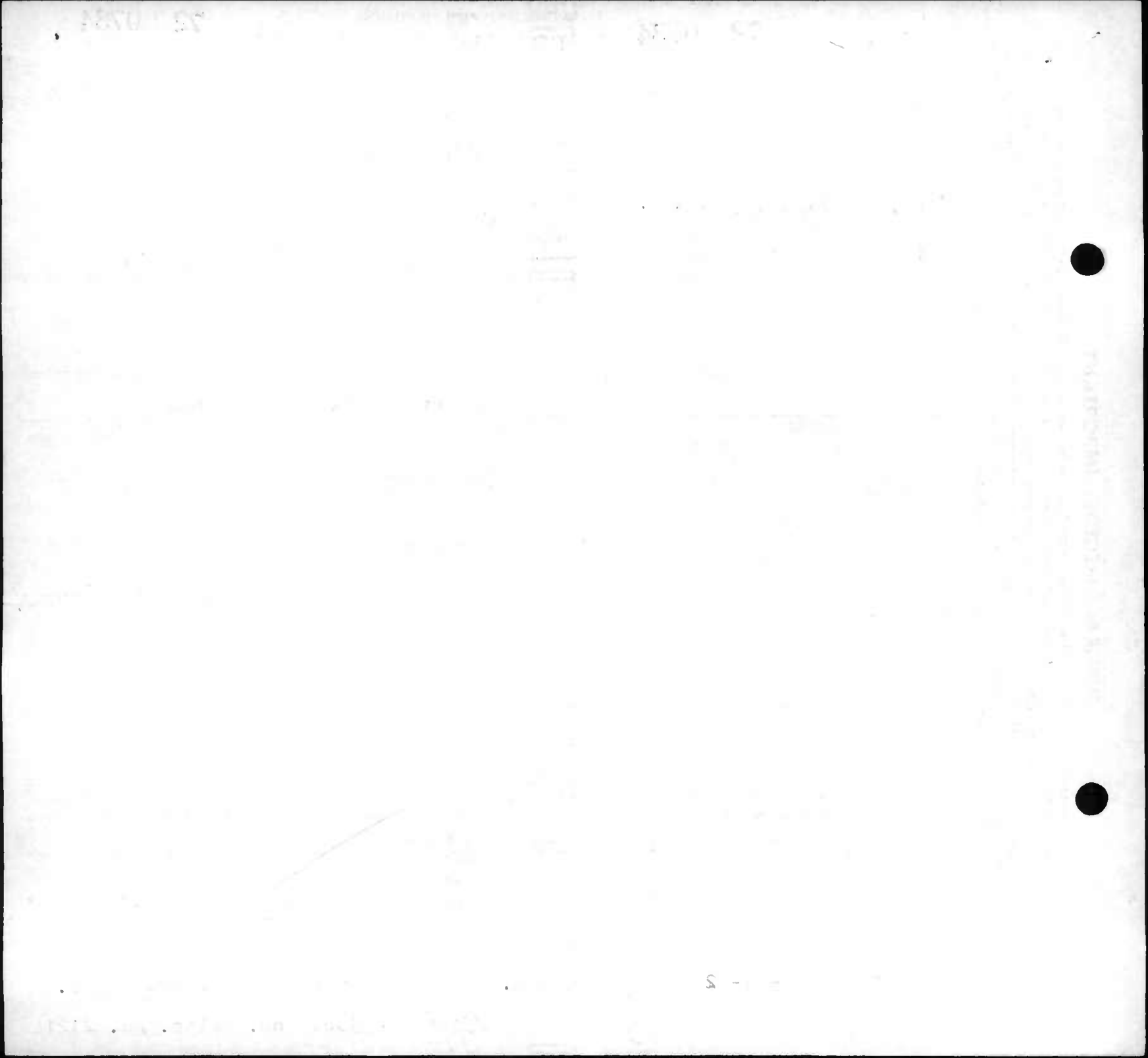




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO.
N-400 72 00734		72 00734		
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		
NOLL, ERIC DAVID		1-20-72 1:00 A.M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION  33 Johns Hopkins Hospital		A. STATE Maryland		
		B. COUNTY Baltimore		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN Forrest Hill		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER 2525 Putnam Road		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 08-24-71	9. AGE (In years last birthday) 4 20
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Went		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland
13. FATHER'S NAME ROBERT NOLL		14. MOTHER'S MAIDEN NAME Edith Merritt		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Robert H Noll
				ADDRESS Same
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				
(A) IMMEDIATE CAUSE Cerebral hemorrhage DUE TO, OR AS A CONSEQUENCE OF:				
(B) Clotting Deficiency DUE TO, OR AS A CONSEQUENCE OF:				
(C)				
II				
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) Yes
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) No		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from 1/19/72 19 to 1/20 1972 that (I) (we) last saw the deceased alive on 1/20 1972 and that (I) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE Winifred B. Parker				23B. DATE SIGNED 1/20/72
23C. PHYSICIAN'S NAME (Type) WINIFRED B. PARKER		23D. ADDRESS Johns Hopkins Hospital - Balto		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-21-72		24C. NAME of CEMETERY or CREMATORY St John's Cem.
		24D. LOCATION Hyde Harford Md.		
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1972		25B. NAME OF REGISTRAR Leonard J. Buck Inc.		25C. FUNERAL DIRECTOR Balto. Md. 21214



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-320		72 00735		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <b>72 00735</b>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>ELIZABETH C. LOTZ</b>				2. DATE AND HOUR OF DEATH <b>1-20-72</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>703</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>00 2311 McELDERRY ST.</b>						C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>2311 McELDERRY ST.</b>									
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5-27-1906</b>		9. AGE (In years last birthday) <b>65</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>CASHIER</b>						10B. KIND OF BUSINESS OR INDUSTRY <b>THEATRE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>									
13. FATHER'S NAME <b>JOHN J. NEUKAM</b>						14. MOTHER'S MAIDEN NAME <b>MARY A. CLEMENT</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>						16. SOCIAL SECURITY NO. <b>215-01-7184A</b>		17. INFORMANT <b>Mr. Joseph L. Lotz - 2311 Mc Elderry St.</b>	
18. <b>412.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>						(A) IMMEDIATE CAUSE <b>Cerebral Vascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(Hypertensive)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.						(B) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF:		<b>12 years</b>	
(C) _____									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				(If in Baltimore City, give exact location)					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR?	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan 25 1963</b> to <b>Jan 20 1972</b> that (I) (we) last saw the deceased alive on <b>Jan 18 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.									
23A. SIGNATURE <b>Israel Rosen M.D.</b>						23B. DATE SIGNED <b>1/22/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>Israel Rosen M.D.</b>						23D. ADDRESS <b>2413 E. Monument St. Baltimore Md.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>				24B. DATE <b>1-24-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>HOLY REDEEMER CEM.</b>			
24D. LOCATION <b>BALTO., MD.</b>				(City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>				25B. NAME OF REGISTRAR <b>77-2000</b>		25C. FUNERAL DIRECTOR <b>Harold Spiller - 2334 Jefferson St.</b>			
ADDRESS									

2000 55

2000 55

1162

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00736	
M-624 72 00736		BIRTH NO.			
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD	
MARSHALL, Bertha (BARBARA)		1/20/72 2:25p. M.		FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)	
33 The Johns Hopkins Hospital		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY		5. SEX 6. RACE	
Maryland Baltimore		C. CITY OR TOWN D. INSIDE CITY LIMITS?		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
Baltimore YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER		8. DATE OF BIRTH	
507 S. 47th Street		507 S. 47th Street		11/23/94	
9. AGE (In years last birthday) 77		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)	
If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.		SEAMSTRESS		MARYLAND	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		Frank Hoffmann		Anna Kross	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No		218 09 9914		Mrs. Rose A. Gryzmala - 507 S. 47th St.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		19. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)		Cerebrovascular accident		immediate	
ANTECEDENT CAUSES		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		20 years	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		athrocardiote heart disease			
		(B) DUE TO, OR AS A CONSEQUENCE OF:		10 years	
		(C) atrial fibrillation			
II		History prior cerebrovascular accident			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
NO					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from May 1969 to December 1971, that (I) (we) last saw the deceased alive on December 28, 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Faith B Davis MD				Jan. 21, 1972	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
FAITH B. DAVIS MD				Baltimore City Hospitals.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
BURIAL		1/25/72		LOUON NATIONAL Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 24 1972		R. B. Davis MD		Faith B Davis - 2334 Jefferson St.	

15 0730 15 11000

U.S.A. Maryland Tailoring Sewing

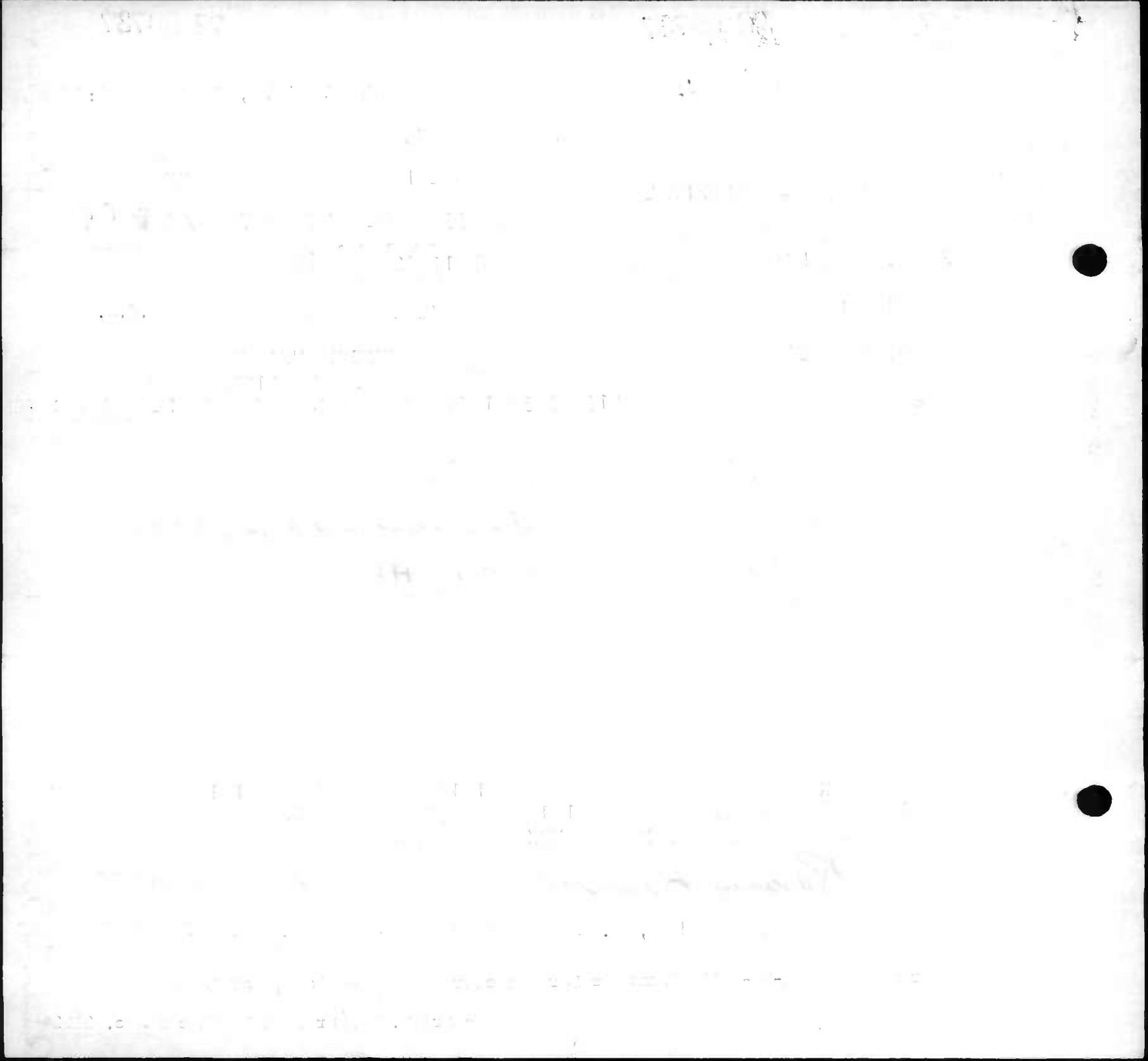
No — 4809014 Mr. J. A. Williams - 207 S. 4th St.

Being 1/25/75 Town National Bm Bm, No. 207 S. 4th St. 4809014

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-612		72 00737		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00737	
1. NAME OF DECEASED (Type or Print) <b>NETTIE GRUBBS</b>				2. DATE AND HOUR OF DEATH <b>JANUARY 19, 1972 6:25 AM.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 ST AGNES HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> C. CITY OR TOWN <b>BALTIMORE</b> E. STREET AND NUMBER <b>3386 DULANY STREET</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07 13 92</b>	9. AGE (In years last birthday) <b>79</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>
13. FATHER'S NAME <b>AUGUST WALTER</b>				14. MOTHER'S MAIDEN NAME <b>HANNAH <del>XXXXX</del> BUSCHMAN</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213 03 2571</b>		17. INFORMANT <b>BALTO MD 21229</b>		ADDRESS <b>1 ST AGNES HOSP RECORDS WILKENS &amp; CATON</b>	
18. <b>412.41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>Fatal arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Aortic stenosis and Regurgitation</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>ASCVD + CHF</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>1 14 1972</b> to <b>1 19 1972</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>1 19 1972</b> and that <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> (did not) view the body after death.							
23A. SIGNATURE <b>Rahman Karimi M.D.</b>				23B. DATE SIGNED <b>1/19/72</b>		23C. PHYSICIAN'S NAME (Type) <b>RAHMAN KARIMI, M.D.</b>	
23A. SIGNATURE <b>Rahman Karimi M.D.</b>		23B. DATE SIGNED <b>1/19/72</b>		23C. PHYSICIAN'S NAME (Type) <b>RAHMAN KARIMI, M.D.</b>		23D. ADDRESS <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVES</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-22-1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 21 1972</b>		25B. NAME OF REGISTRAR <b>Howard H. Hubbard</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave. 21229</b>	





B-260

72 00738

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00738

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>CHESTER E. BECKER</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>January 20, 1972 12:42 A.M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>40 St. Agnes Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 20, 1972 12:42 A.M.</b>	
6. SEX <b>Male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>10-6-1924</b>		10. AGE (In years lost birthday) <b>47</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Chester L. Becker</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
15. MOTHER'S MAIDEN NAME <b>Elise Geatler</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes W W II</b>		17. SOCIAL SECURITY NO. <b>217-16-6904</b>	
18. INFORMANT <b>Mrs. Alice M. Becker, 5011 Gateway Terrace</b>		ADDRESS <b>21227</b>	
19. CAUSE OF DEATH <b>412.4 I Arteriosclerotic cardiovascular disease</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type): <b>Charles S. Springate, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 20, 1972</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-24-1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>	
25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave. 21229</b>	

15 0038

15 0038

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE ASSISTANT SECRETARY FOR TECHNICAL ASSISTANCE

WASHINGTON, D. C. 20250

TO: DIRECTOR, INTERNATIONAL AGRICULTURAL MECHANIZATION CENTER

FROM: ASSISTANT SECRETARY FOR TECHNICAL ASSISTANCE

SUBJECT: REQUEST FOR INFORMATION

RE: REQUEST FOR INFORMATION

DATE: 10/1/68

1. The following information is requested for the purpose of the study:

2. The information requested is as follows:

1. Name of the organization	2. Address	3. Telephone number
4. Name of the person to be contacted	5. Position	6. Date of completion
7. Name of the person to be contacted	8. Position	9. Date of completion
10. Name of the person to be contacted	11. Position	12. Date of completion
13. Name of the person to be contacted	14. Position	15. Date of completion
16. Name of the person to be contacted	17. Position	18. Date of completion
19. Name of the person to be contacted	20. Position	21. Date of completion
22. Name of the person to be contacted	23. Position	24. Date of completion
25. Name of the person to be contacted	26. Position	27. Date of completion
28. Name of the person to be contacted	29. Position	30. Date of completion
31. Name of the person to be contacted	32. Position	33. Date of completion
34. Name of the person to be contacted	35. Position	36. Date of completion
37. Name of the person to be contacted	38. Position	39. Date of completion
40. Name of the person to be contacted	41. Position	42. Date of completion
43. Name of the person to be contacted	44. Position	45. Date of completion
46. Name of the person to be contacted	47. Position	48. Date of completion
49. Name of the person to be contacted	50. Position	51. Date of completion
52. Name of the person to be contacted	53. Position	54. Date of completion
55. Name of the person to be contacted	56. Position	57. Date of completion
58. Name of the person to be contacted	59. Position	60. Date of completion
61. Name of the person to be contacted	62. Position	63. Date of completion
64. Name of the person to be contacted	65. Position	66. Date of completion
67. Name of the person to be contacted	68. Position	69. Date of completion
70. Name of the person to be contacted	71. Position	72. Date of completion
73. Name of the person to be contacted	74. Position	75. Date of completion
76. Name of the person to be contacted	77. Position	78. Date of completion
79. Name of the person to be contacted	80. Position	81. Date of completion
82. Name of the person to be contacted	83. Position	84. Date of completion
85. Name of the person to be contacted	86. Position	87. Date of completion
88. Name of the person to be contacted	89. Position	90. Date of completion
91. Name of the person to be contacted	92. Position	93. Date of completion
94. Name of the person to be contacted	95. Position	96. Date of completion
97. Name of the person to be contacted	98. Position	99. Date of completion
100. Name of the person to be contacted	101. Position	102. Date of completion

3. The information requested is as follows:

4. The information requested is as follows:

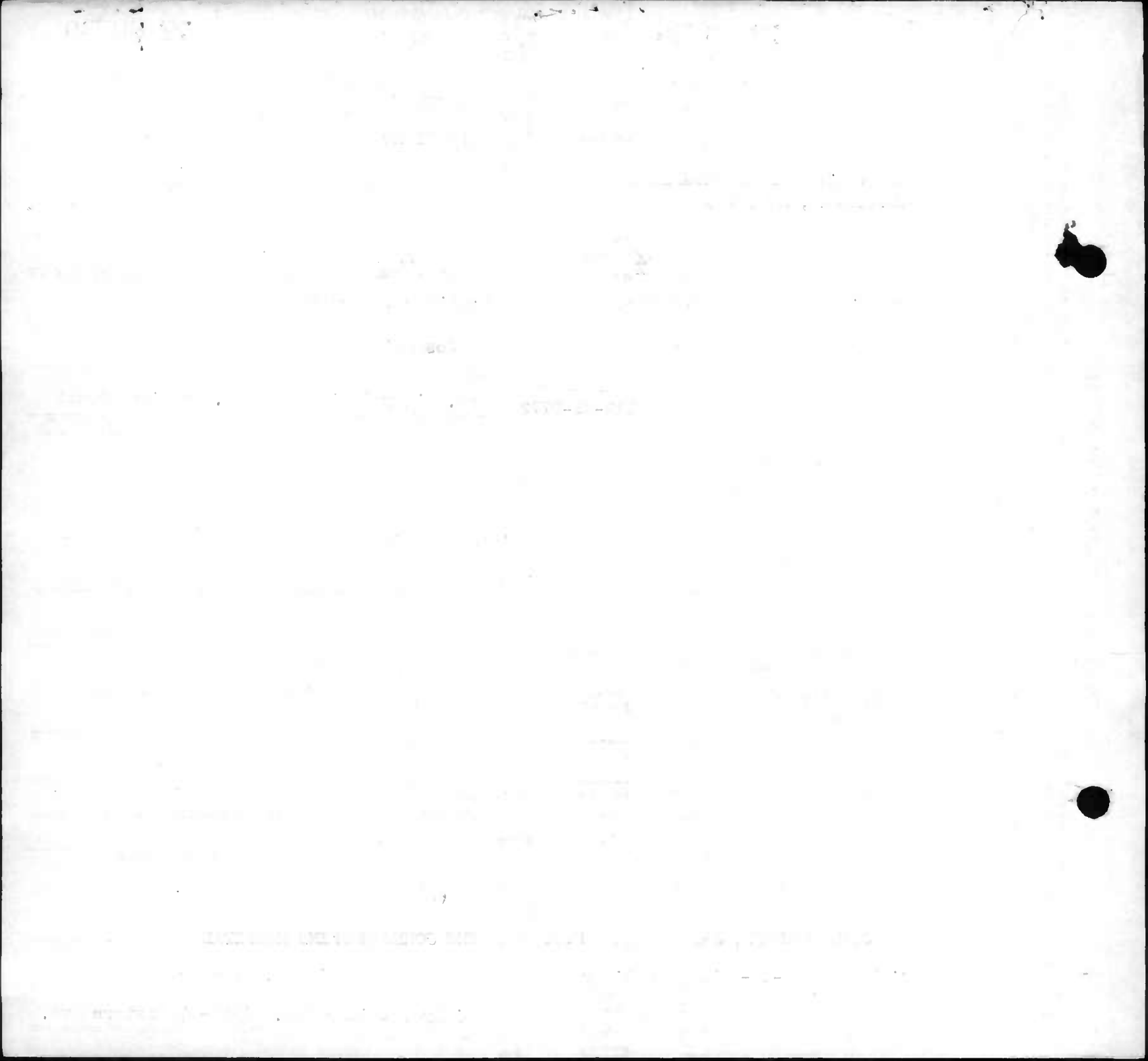
5. The information requested is as follows:

6. The information requested is as follows:

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 00739</b>	
B-651 BIRTH NO.		72 00739		CERTIFICATE OF DEATH	
1. NAME OF DECEASED <b>BURNIP Catherine M.</b>			2. DATE AND HOUR OF DEATH <b>1-22-72 4:21 am</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>105</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b> <b>33 BALTIMORE, MD 21205</b>			C. CITY OR TOWN <b>BALTIMORE MD</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <b>02-11-03</b>		9. AGE (In years last birthday) <b>68</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
13. FATHER'S NAME <b>Fontz</b>			14. MOTHER'S MAIDEN NAME <b>Josephine Conway</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218-30-1870</b> <b>212-03-9772</b>		17. INFORMANT <b>Mrs. Mildred Finn</b>	
				ADDRESS <b>406 S. Madeira Street</b>	
18. <b>7-12-41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
(A) IMMEDIATE CAUSE <b>Cardiorespiratory Arrest</b> DUE TO, OR AS A CONSEQUENCE OF:					
(B) <b>Pneumonia, Suspected Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF:					
(C) <b>ASCVD</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (if in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>January 20 1972</b> to <b>January 22 1972</b> that (I) (we) last saw the deceased alive on <b>January 22 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>I. H. Varnell Jr.</b>				23B. DATE SIGNED <b>1/22/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>I. H. VARNELL, JR.</b>				23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>	
24A. BURIAL CREMATION, 24B. DATE OF REMOVAL (Specify) <b>Burial 1-25-1972</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Baltimore</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Lilly &amp; Zeiler Inc.</b>	
				ADDRESS <b>1901-07 Eastern Ave.</b>	



THE BODY OF VANCE WILLIAMS HAS BEEN RELEASED AS NON MED BY  
FUNERAL DIRECTOR: IMPORTANT

DR. KORNBLUM OF THE MEDICAL EXAMINER'S OFFICE  
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>W-452</u>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00740</u>			
1. NAME OF DECEASED (Type or Print) <u>Celester</u> <u>VADER, WILLIAMS</u>				2. DATE AND HOUR OF DEATH <u>01-22-72</u> <u>11:30 A.M. M.</u>							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>33 THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>806</u>							
5. SEX <u>FEMALE</u>		6. RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>02-28-04</u> <u>67</u>					
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Wade, North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>Matthew Kelly</u> <u>MATTHEW KELLY</u>				14. MOTHER'S MAIDEN NAME <u>EMMA MCKETHAN</u>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>244 38 4732</u>		17. INFORMANT <u>Mr. Willie Williams Sr. 1806 N. Bethel St.</u>		ADDRESS <u>21213</u>					
18. <u>7-10-9 1</u> DISEASE OR CONDITION DIRECTLY NOT A RESULT OF UNDERLYING CAUSE LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) CHIEF OR ASS'T. MEDICAL EXAMINER DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Probable Acute MI</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Ca of Bladder</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 hrs.</u>					
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from <u>01-22-19-72</u> to <u>01-22-19-72</u> that (I) (we) last saw the deceased alive on <u>19</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <u>JOSEPH P. FINIZIO</u> <u>J.P. Finizio M.D.</u>				23B. DATE SIGNED <u>01-22-72</u>		23C. PHYSICIAN'S NAME (Type) <u>J.P. Finizio M.D.</u>					
23D. ADDRESS <u>THE JOHNS HOPKINS HOSPITAL</u>				23E. NAME OF REGISTRAR <u>DEGREE</u>		23F. FUNERAL DIRECTOR <u>1735 Harford Avenue 21213</u> <u>Marshall W. Jones, Jr.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>transit-burial</u>		24B. DATE <u>1-27-1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>McKethan Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Dunn, North Carolina</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1972</u>				25B. NAME OF REGISTRAR <u>20000</u>							

35

01-55 35

01-55

NO

OF THE MEDICAL EXAMINER  
AND SMALLER  
AND MITTLE HVS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<b>S-420</b> <b>72 00741</b> <b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>72 00741</b>	
BIRTH NO. <b>72 00741</b>		2. DATE AND HOUR OF DEATH <b>Jan. 20 1972 7:58 A.M.</b>	
1. NAME OF DECEASED (Type or Print) <b>Scales, Violet</b>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1601</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>39 Provident Hosp.</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>39 Provident Hosp.</b>		E. STREET AND NUMBER <b>1003 Bennett Place</b>	
5. SEX <b>F</b>	6. RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12-20-05</b>
9. AGE (In years last birthday) <b>66</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hodge Smith</b>		14. MOTHER'S MAIDEN NAME <b>Mamie Harkins</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give year or dates of service <b>No</b>		16. SOCIAL SECURITY NO. <b>216-05-9076A</b>	
17. INFORMANT <b>Mrs. Canelia McKee</b>		ADDRESS <b>523 Arlington Ave.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>250.9 I Hypertensive cardiovascular heart disease</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>(A) IMMEDIATE CAUSE @ Actual flutter</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>CVA (Rt.)</b> <b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b> <b>Diabetes mellitus.</b> <b>(C)</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>disease</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 13 1972</b> to <b>Jan. 20 1972</b> that (I) (we) last saw the deceased alive on <b>Jan. 20 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>V. Chitraplee</b>		23B. DATE SIGNED <b>Jan. 20, 72</b>	
23C. PHYSICIAN'S NAME (Type) <b>V. Chitraplee</b>		23D. ADDRESS <b>Provident Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-25-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>John E. ...</b>	
25C. FUNERAL DIRECTOR <b>89856 ...</b>		ADDRESS <b>1003 Bennett Pl</b>	

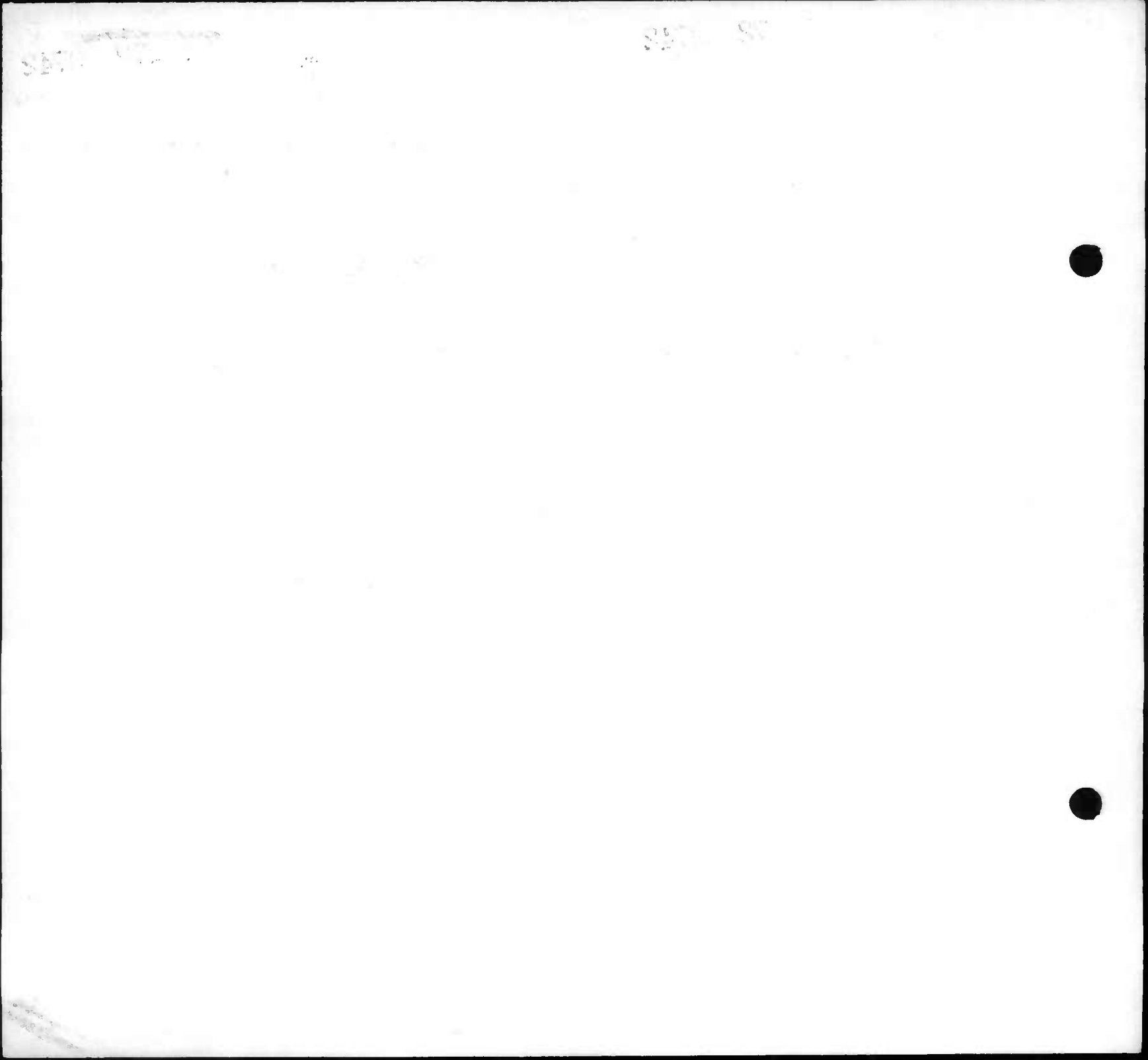




**FUNERAL DIRECTOR: IMPORTANT**

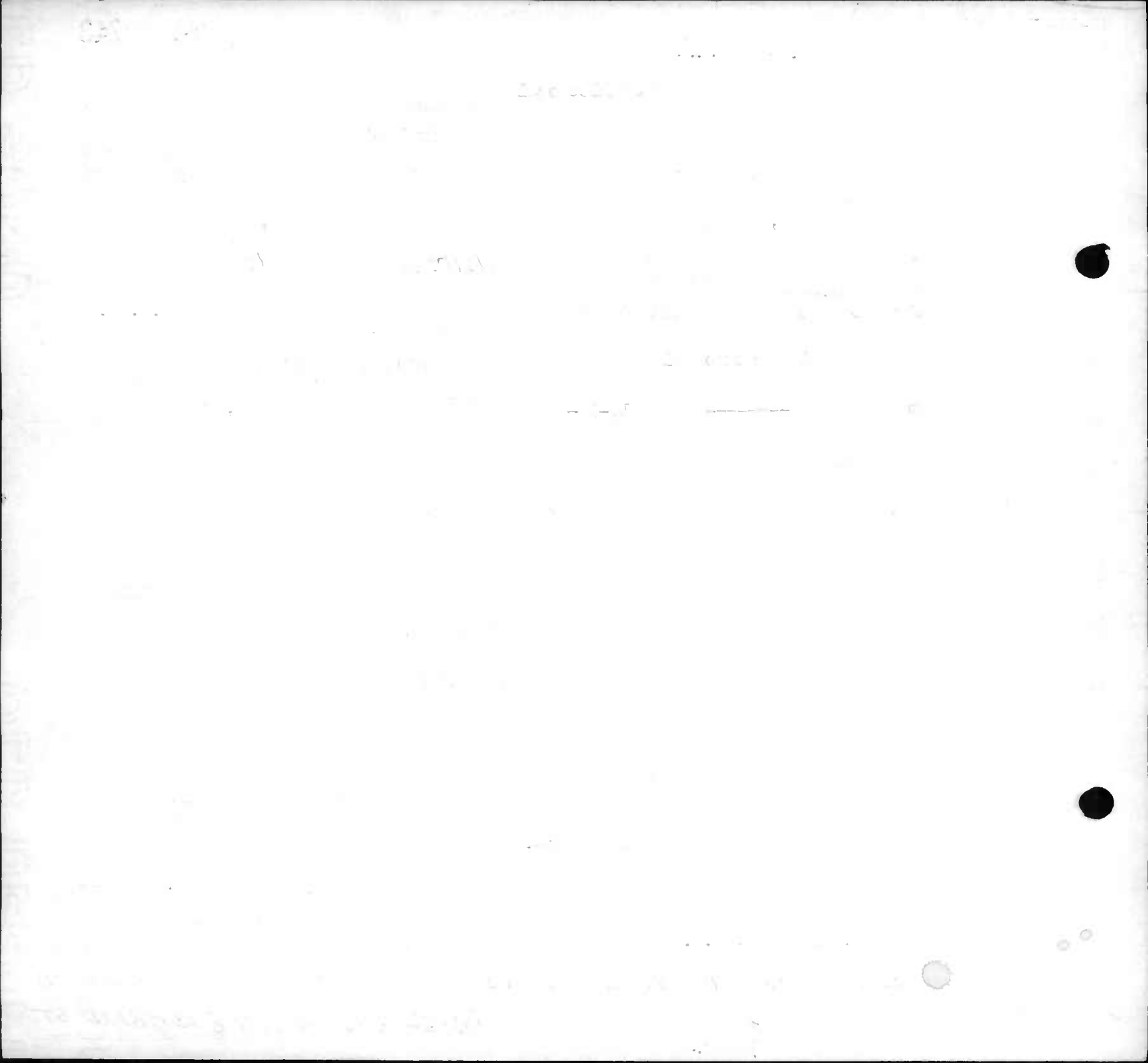
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>A-536 72 00742</b></p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>CERTIFICATE OF DEATH</b></p>		<p>REG. NO. <b>72 00742</b></p>	
<p>BIRTH NO. <b>72 00742</b></p>		<p>1. NAME OF DECEASED (Type or Print) <b>Anderson, James</b></p>	
<p>2. DATE AND HOUR OF DEATH <b>Jan. 19, 1972 10:55 PM</b></p>		<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>Dukeland Nursing Home</b></p>	
<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>27 North Ellamont Street</b> B. COUNTY <b>Baltimore</b></p>		<p>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>5. SEX <b>M.</b> 6. RACE <b>Negro</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>		<p>8. DATE OF BIRTH <b>8/15/1900</b> 9. AGE (in years last birthday) <b>71</b></p>	
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p>		<p>10B. KIND OF BUSINESS OR INDUSTRY</p>	
<p>11. BIRTHPLACE (State or foreign country) <b>Virginia</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME <b>JOHN E ANDERSON</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>POCANANTAS HARTMAN</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>		<p>16. SOCIAL SECURITY NO.</p>	
<p>17. INFORMANT <b>Kath Logan - LPN - Dukeland Nursing Home</b></p>		<p>ADDRESS</p>	
<p>18. <b>412.2 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebrovascular Accident</b></p>		<p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(B) <b>Arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF:</p>	
<p>(C) <b>Hypertensive Cardio-vascular disease</b></p>		<p>(D) <b>Arthritis</b></p>	
<p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>			
<p>19A. DATE OF OPERATION</p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	
<p>20A. AUTOPSY? (Yes or No)</p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>Dec 16 19 71</b> to <b>Jan 19 19 72</b> that (I) (we) lost saw the deceased alive on <b>Jan 19 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>Joseph Jack, Jr. M.D.</b></p>		<p>23B. DATE SIGNED <b>Jan. 19, 1972</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>Joseph Jack, Jr. M.D.</b></p>		<p>23D. ADDRESS <b>4200 Edmondson Ave. Balto. Md.</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>1-24-72</b></p>	
<p>24C. NAME of CEMETERY or CREMATORY <b>Verdun Park</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Verdun Park</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>W. E. Jones</b></p>	
<p>25C. FUNERAL DIRECTOR <b>W. E. Jones</b></p>		<p>ADDRESS <b>Verdun Park</b></p>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

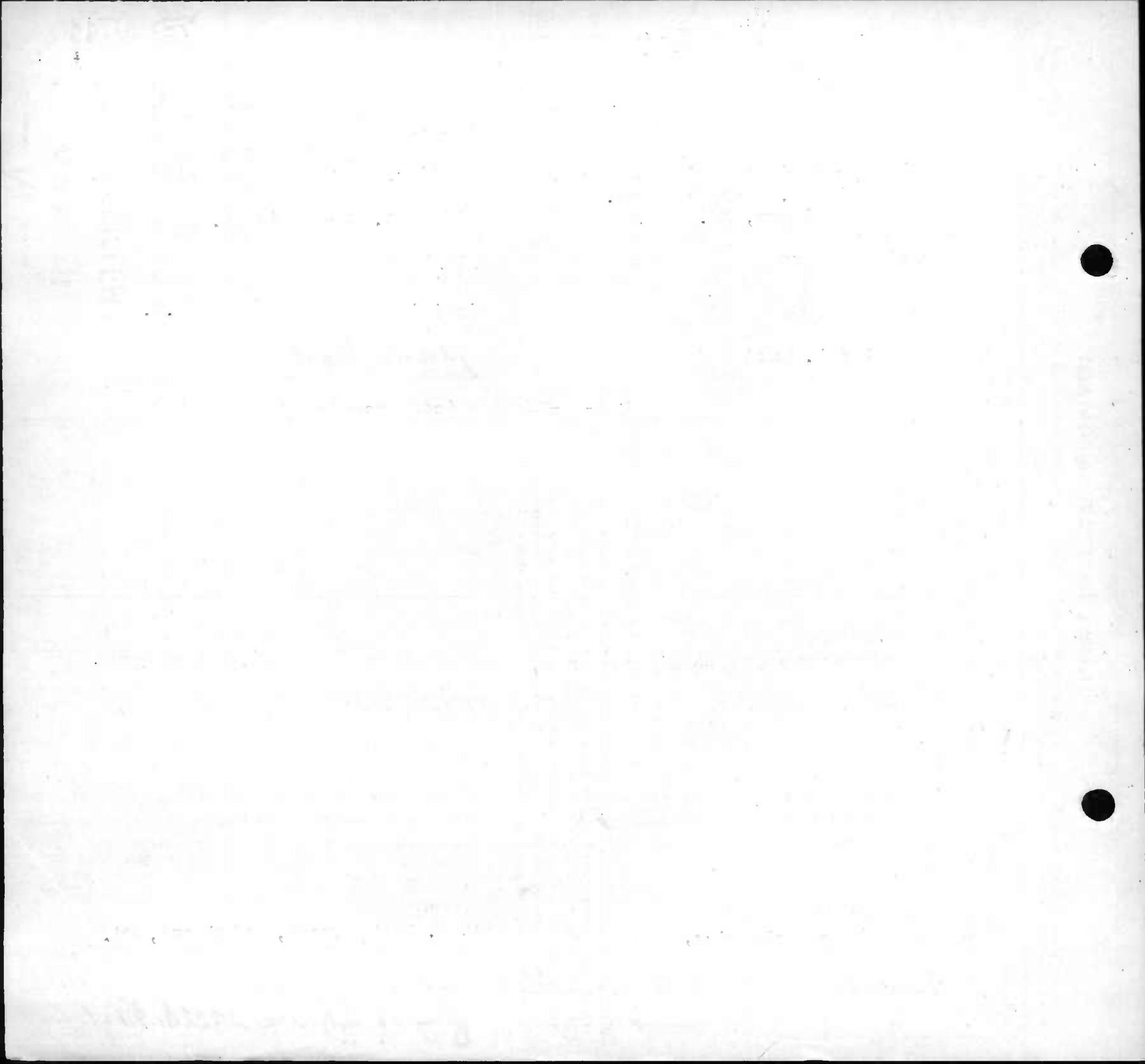
BIRTH NO. <b>72 00743</b>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <b>72 00743</b>	
1. NAME OF DECEASED (Type or Print) <b>Theresa Biechocki Or Piechocki</b>			2. DATE AND HOUR OF DEATH <b>1/21/72 10:47 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland</b>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1956 Stanhope Road</b> <b>3rd floor</b>		
5. SEX <b>Female</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/27/1892</b>	9. AGE (In years last birthday) <b>79</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Charwoman</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Equitable Bldg</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S. A.</b>			13. FATHER'S NAME <b>William Buczkowski</b>		
14. MOTHER'S MAIDEN NAME <b>Apolonia Wozniak</b>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>219-34-4448</b>			17. INFORMANT <b>BCH-Records</b> ADDRESS <b>4940 Eastern Avenue Baltimore, Maryland</b>		
18. <b>513X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Necrotizing Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>ASCVD &amp; old MI</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (A) (this hospital) attended the deceased from <b>1/20/1972</b> to <b>1/21/1972</b> that (I) (we) last saw the deceased alive on <b>1/21/1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>R. Einhorn, M.D.</b>			23B. DATE SIGNED <b>1/21/72</b>		
23C. PHYSICIAN'S NAME (Type) <b>R. Einhorn, M.D.</b>			23D. ADDRESS <b>Baltimore City Hospitals 4940 Eastern Avenue 21224</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>Jan 24 72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Holy Cross Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>GERMANY HILL RD BALTO MD</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>			
25B. NAME OF REGISTRAR <b>John E. Kelly, M.D.</b>		25C. FUNERAL DIRECTOR <b>DOPEL BROS INC 1800 E LOMBARD ST</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-520		72 00744		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00744	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) Marie Knox				2. DATE AND HOUR OF DEATH JAN. 13, 1972 1 7 PM A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission) A. STATE Maryland B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS?			
90		House in the Pines Belvedere 2525 W. Belvedere Ave. Baltimore, Md. 21215		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX Female		6. RACE Negro		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6/24/1884		9. AGE (In years last birthday) 87	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A			
13. FATHER'S NAME Charles O. Ward				14. MOTHER'S MAIDEN NAME Jennie Love					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 212-42-7540		17. INFORMANT Medical Records		ADDRESS			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 years			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from July 1964 to Jan 1972, that (I) (we) last saw the deceased alive on Jan 5 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE Sheldon Goldgeier				23B. DATE SIGNED Jan. 13, 1972					
23C. PHYSICIAN'S NAME (Type) Sheldon Goldgeier, MD				23D. ADDRESS 848 W. 36th Street, Baltimore, Md.					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-18-72		24C. NAME OF CEMETERY or CREMATORY Western Star Cemetery		24D. LOCATION (City, town, or county) (State) Catonville, Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1972		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR Joseph L. Russ		ADDRESS 2222 W. North Ave.			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>X-520</b></span> <span><b>72 00745</b></span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>CERTIFICATE OF DEATH</b></span> <span>REG. NO. <b>72 00745</b></span> </div>	
BIRTH NO. <span style="float: right;"><b>72 00745</b></span>	
1. NAME OF DECEASED (Type or Print) <b>Seymour Knox</b>	
2. DATE AND HOUR OF DEATH <b>Jan. 19, 1972 11:00 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3102 Auchentorpy Terrace</b>	
4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Ind.</b> B. COUNTY <b>1304</b>	
C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>3102 Auchentorpy Terrace</b>	
5. SEX <b>Male</b> 6. RACE <b>Colored</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <b>Jan 17, 1902</b> 9. AGE (In years last birthday) <b>72</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
11. BIRTHPLACE (State or foreign country) <b>Accomack Co., Va.</b>	12. CITIZEN OF WHAT COUNTRY?
13. FATHER'S NAME <b>Douglas Knox</b>	
14. MOTHER'S MAIDEN NAME <b>Annie</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>28-16-34129</b>	
17. INFORMANT <b>Clayton Knox</b> ADDRESS <b>3102 Auchentorpy Terrace</b>	
18. <b>431.9 I</b> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cerebral haemorrhage</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerosis, general</b>	
(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>16 hrs.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Many years.</b> (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).	
19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>April 19 69</b> to <b>Jan 19 72</b> that (I) (we) last saw the deceased alive on <b>Jan 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.	
23A. SIGNATURE <b>John Elden Howard, M.D.</b>	
23B. DATE SIGNED <b>Jan. 24 72</b>	
23C. PHYSICIAN'S NAME (Type) <b>John Elden Howard, M.D.</b>	
23D. ADDRESS <b>12 East Eager St. Balt. Ind.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>1-24-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Arbuthnot Park Arbuthnot</b> 24D. LOCATION (City, town, or county) <b>Ind.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b> 25B. NAME OF REGISTRAR <b>John E. Howard</b>	
25C. FUNERAL DIRECTOR <b>George J. Kues</b> ADDRESS <b>2221 N. North Ave.</b>	

25 11/10 87

20 88



1  
W. 252

J-525

72 00746 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 72 00746

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>CHARLES WIGGINS Johnson</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1309 N. Freemount Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 16 1972 4:10 p.m.</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1403</b>	
6. SEX <b>male</b>	7. RACE <b>negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH		10. AGE (In years last birthday) <b>87</b>	If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
11. BIRTHPLACE (State or foreign country) <b>Edent. N. Carolina</b>		12. CITIZEN OF WHAT COUNTRY?		E. STREET AND NUMBER <b>2103 Division St.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hankins</b>		14B. KIND OF BUSINESS OR INDUSTRY		13. FATHER'S NAME <b>unknown</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO.		15. MOTHER'S MAIDEN NAME <b>unknown</b>	
18. INFORMANT <b>Genevieve Johnson</b>		ADDRESS <b>2812 Rockrose Ave.</b>			
19. <b>571.8</b>		CAUSE OF DEATH <b>Fatty metamorphosis of liver</b>			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		(C)			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>R. Fisher</b> M.D. EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-20-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Not Calvary Cemetery Brooklyn, Md.</b>	
24D. LOCATION (City, town, or county) (State) <b>Ind.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>Valerie E. Taylor, R.D.</b>	
25C. FUNERAL DIRECTOR <b>Joseph H. Rues</b>		ADDRESS <b>2222 N. North Ave.</b>			

1 7 7 2 0 0 0 7 1 1

35 00718

35 00718

memorandum

memorandum  
memorandum

OFFICE OF THE

General 100-75,000. Bureau of Prisons  
Federal Bureau of Investigation

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 00747

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 72 00747

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

PARKER, Horace

2. DATE AND HOUR OF DEATH

1-23-72

6 a. m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

38 UNIV. of MD. HOSPITAL.

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE

826, VINE ST. MARYLAND 1801

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

826 Vine St.

5. SEX

Male

6. RACE

Colored

7. MARRIED ☒ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

DATE OF BIRTH

6-2-13

9. AGE (in years  
last birthday)

38

If Under 1 Yr.

Months

Days

If Under 24 Hrs.  
Hours Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

B+O R.R.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

Horace Parker

14. MOTHER'S MAIDEN NAME

Edna Barnes

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) (If yes, give war or dates of service)

16. SOCIAL  
SECURITY NO.

185-09-8963

17. INFORMANT

ADDRESS

Louise Parker 255 N. Monmouth St.

18. 146.0 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Broncho pneumonia (Pneumonia)

2 weeks

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Carcinoma of Tongue

16 months

(C)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

1-14-72

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

Tumor obs

20A. AUTOPSY? (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg.,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At

Work ☐

Not While

At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 12-26 19 71 to 1-23 19 72  
that (I) (we) lost saw the deceased alive on 1-22 19 72 and that (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

J.H. MATHER

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

1-23-72

23C. PHYSICIAN'S  
NAME (Type)

J.H. MATHER

DEGREE

23D. ADDRESS

University Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1/26/72

24C. NAME OF CEMETERY or CREMATORY

Mt Calvary

24D. LOCATION

(City, town, or county)

(State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 24 1972

25B. NAME OF REGISTRAR

E. J. Barber, M.D.

25C. FUNERAL DIRECTOR

Charles G. Rice 66 W. Barnes St.

ADDRESS

1971-82

1971-82

1  
B 240

## BALTIMORE CITY HEALTH DEPARTMENT

72.00748

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72.00748

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Arthur Beasley</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 19 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>37 Mercy Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 19 72 2:40 a.m.</b>	
6. SEX <b>male</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1547</b>	
7. RACE <b>Negro</b>		C. CITY OR TOWN <b>Balto.</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>4/2/50</b>		E. STREET AND NUMBER <b>2106 Braddish</b>	
10. AGE (In years last birthday) <b>21</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>William Beasley</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		15. MOTHER'S MAIDEN NAME <b>Geraldine Shannon</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes 1968 to 1971</b>		17. SOCIAL SECURITY NO. <b>214-54-3743</b>	
18. INFORMANT <b>Geraldine Beasley</b>		ADDRESS <b>2106 Braddish Av.</b>	
19. <b>E 965X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		CAUSE OF DEATH <b>Gunshot wound of abdomen</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) _____  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>RESTAURANT</b>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>Tommies Restaurant- 2101 Penna. Ave.</b>		22D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <b>1 18 72 10:00 p.m.</b>	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Subject shot during altercation.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE: <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>1/19/72</b> EXAMINER'S NAME (Type)			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>		24D. LOCATION (City, town, or county) (State) <b>Brooklyn, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Jaber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Charles A. Rice</b>		ADDRESS <b>661 W. Barre St.</b>	



1  
VV 425  
72 00749

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00749

BIRTH NO.

1. NAME OF DECEASED (Type or Print) Roberta Carter Wilson		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 22 Year 72		Hour M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 1021 N. Wolfe St.		3. DATE PRONOUNCED DEAD Month 1 Day 22 Year 72		Hour 3:50 a. M.	
6. SEX female		7. RACE Negro		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH 7-26-11		10. AGE (In years last birthday) 60		11. BIRTHPLACE (State or foreign country) Ga.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME Toby Mason		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife	
15. MOTHER'S MAIDEN NAME Amanda		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 253-05-6062	
18. INFORMANT John T. Wilson		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION 0		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) no	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE: [Signature] M.D. EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 1/22/72					
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-26-72		24C. NAME of CEMETERY or CREMATORY Cedar Hill Cemetery	
24D. LOCATION (City, town, or county) (State) Anne Arundel City., Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 24 1972		25B. NAME OF REGISTRAR Robert E. Johnson	
25C. FUNERAL DIRECTOR Wm C March		25D. ADDRESS 928 E North Ave.		25E. DATE 1/22/72	



ST. LOUIS

ST. LOUIS

ST. LOUIS, MO., MAY 1, 1900

ST. LOUIS, MO., MAY 1, 1900





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B23572 00750

BALTIMORE CITY HEALTH DEPARTMENT

## CERTIFICATE OF DEATH

REG. NO. 72 00750

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Boston, Florence

2. DATE AND HOUR OF DEATH

11/20/72

11:30 a.m.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)

Baltimore City Hospitals

4940 Eastern Avenue

Baltimore, Maryland 21224

4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  
A. STATE B. COUNTY

Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

4725 Beauford Avenue 21215

5. SEX

Female

6. RACE

Negro

7. MARRIED ☐ NEVER MARRIED ☐WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH

5-9-98

9. AGE (In years  
last birthday)

73

If Under 1 Yr.

Months: Days:

If Under 24 Hrs.

Hours: Min.

10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

N.C.

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

UNKNOWN

14. MOTHER'S MAIDEN NAME

UNKNOWN

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

28-09-8919

17. INFORMANT

4940 Eastern Avenue

ADDRESS

BCH: Records Baltimore, Maryland

21224

18. 412.4 I

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Cardiac Arrest

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

10 min

(B)

DUE TO, OR AS A CONSEQUENCE OF:

CHF, ASCVD

4 years

(C)

DUE TO, OR AS A CONSEQUENCE OF:

Chronic Brain Syndrome

4 years

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY (Yes or No)

No

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF  
DEATH (notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 11/20/72 to 11/20/72  
that (I) (we) last saw the deceased alive on 11/20/72 and that (in my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

23C. PHYSICIAN'S  
NAME (Type)

Michele Codrin M.D.

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

11/20/72

23D. ADDRESS

Baltimore City Hospitals

4940 Eastern Avenue Baltimore, Maryland 21224

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-25-72

24C. NAME of CEMETERY or CREMATORY

Mt. Auburn Cem.

24D. LOCATION

Baltimore Md.

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 24 1972

25B. NAME OF REGISTRAR

Robert E. Johnson M.D.

25C. FUNERAL DIRECTOR

Wm C. March

ADDRESS

928 E North Ave



10-11-59 10-11-59 10-11-59

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 00751		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00751'	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>TAYLOR JAMES</b>		2. DATE AND HOUR OF DEATH <b>1-18-1972 12.25 AM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1203</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>44 UNION Memorial Hospital</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>M</b>		6. RACE <b>N</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>EMPLOYEE Daiser Corp. GEN. Contract.</b>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <b>3-9-32</b> 9. AGE (In years last birthday) <b>39</b> If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
13. FATHER'S NAME <b>MOSES TAYLOR</b>		14. MOTHER'S MAIDEN NAME <b>GRACE FREDERICK</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b> 12. CITIZEN OF WHAT COUNTRY <b>U. S. A.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>GERTRUDE JOHNSON 3406 N. MOLLBERG</b> ADDRESS	
18. <b>482.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>CARDIAC ARREST</b> (B) <b>Bylated Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>SEPSIS</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
MEDICAL CERTIFICATION		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>DIABETES</b>			
		19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>1-17</b> 19 <b>72</b> to <b>1-18</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1-18</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Grattilano MD</b>		23B. DATE SIGNED <b>1-18-72</b>		23C. PHYSICIAN'S NAME (Type) <b>Cor 405 A. Battilana MD</b>	
23D. ADDRESS <b>Union Memorial Hospital</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1-22-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>MT. CALVARY</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO - MD.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>John E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>John E. Taylor, M.D.</b> ADDRESS	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>H-625</u> <u>72 00752</u>		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH <u>X</u>		REG. NO. <u>72 00752</u>	
1. NAME OF DECEASED (Type or Print) <u>JESSE Harrison Harkins</u> <u>HARKINS JESSE</u>				2. DATE AND HOUR OF DEATH <u>1/21/72</u> <u>12:10 P M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>South Baltimore General Hospital</u> FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>43</u>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Harford Co.</u> <u>6200</u>			
5. SEX <u>M</u>		6. RACE <u>Caucasian</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-6-69</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE - MD.</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
13. FATHER'S NAME <u>BENJAMIN W. BENJAMIN Wilson Harkins</u>				14. MOTHER'S MAIDEN NAME <u>JOYCE Isabelle Adams JOYCE ADAMS</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT (Father) <u>457-5641</u> ADDRESS <u>2153#2 Box#252</u> <u>Mr Benjamin W. Harkins Street, Maryland 21154</u>			
18. <u>23711</u> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>BRAIN TUMOR</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE</u> <u>DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(B) DUE TO, OR AS A CONSEQUENCE OF:</u> <u>(C) DUE TO, OR AS A CONSEQUENCE OF:</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>28 days</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) 1 Month ( ) Day ( ) Year ( ) Hour ( )		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/23</u> 19 <u>71</u> to <u>1/21</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/21</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>DR ANTE GRGIC</u>				23B. DATE SIGNED <u>1/21 72</u>		23C. PHYSICIAN'S NAME (Type) <u>DR ANTE GRGIC</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>JAN. 24, 1972</u>		24C. NAME of CEMETERY or CREMATORY <u>Bel Air Memorial Gardens</u>		24D. LOCATION (City, town, or county) (State) <u>Bel Air, Harford Co., Maryland 21014</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. [unclear]</u>		25C. FUNERAL DIRECTOR <u>Joseph William Foster</u> ADDRESS <u>W. Broadway &amp; Williams St. Bel Air, Maryland 21014</u>			

11

11 1974

11 1974

11 1974

11

11 1974

11 1974

11 1974

11 1974

11 1974

11 1974

11 1974

11 1974

11 1974

11 1974

11 1974

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-420		72 00753		BALTIMORE CITY HEALTH DEPARTMENT		72 00753	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>Adam Kluga (Adam Kluga)</u>				2. DATE AND HOUR OF DEATH <u>22 January 1972</u> <u>3:24</u> A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2402</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Harbor View Nursing Center</u> <u>1213 Light Street</u> <u>Baltimore, Maryland 21230</u>		IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>636 S. Clement Street</u>		<u>21230</u>		5. DATE OF BIRTH <u>14 October 1894</u>		6. AGE (In years last birthday) <u>77</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		9. KIND OF BUSINESS OR INDUSTRY <u>Shipyards</u> <u>Bethlehem Steel</u>		10. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>	
11. FATHER'S NAME <u>Unknown (Kluga)</u>		12. MOTHER'S MAIDEN NAME <u>Helen (Unknown)</u>		13. CITIZEN OF WHAT COUNTRY? <u>United States A</u>		14. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Unknown No.</u>	
15. SOCIAL SECURITY NO. <u>220-05-8774</u>		16. INFORMANT <u>Miss Dorothy Hendricks</u> <u>Chart at Harbor View</u>		ADDRESS <u>Same</u>		17. CAUSE OF DEATH	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Pneumonia</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		19. IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>ASCVD with Advanced Cerebrovascular</u> <u>and Peripheral Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>		20. YEARS	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <u>Atrial Fibrillation</u>		23. YEARS		24. MEDICAL CERTIFICATION	
25. DATE OF OPERATION <u>19 February 1969</u>		26. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>No</u>		27. AUTOPSY? (Yes or No) <u>No</u>		28. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
29. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <input type="checkbox"/>		30. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>None</u>		31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		32. HOW DID INJURY OCCUR?	
33. TIME OF INJURY (Approx.) <u>None</u>		34. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		35. DATE OF DEATH <u>22 January 1972</u>		36. SIGNATURE <u>Peter H. Rheinheimer, M.D.</u> Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
37. PHYSICIAN'S NAME (Type) <u>Peter H. Rheinheimer, M.D.</u>		38. ADDRESS <u>Harbor View Nursing Center, 1213 Light St.</u>		39. DATE SIGNED <u>22 January 1972</u>		40. SIGNATURE <u>Curtis E. Evans</u>	
41. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		42. DATE <u>Tues Jan 25 1972</u>		43. NAME OF CEMETERY OR CREMATORY <u>Holy Cross Cem.</u>		44. LOCATION (City, town, or county) (State) <u>Brooklyn A A Co Md</u> <u>CURTIS E. EVANS</u>	
45. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1972</u>		46. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		47. FUNERAL DIRECTOR <u>C. J. Evans</u>		48. ADDRESS <u>1400 S. Charles</u> <u>Balto Md</u>	

107- ST

107- ST

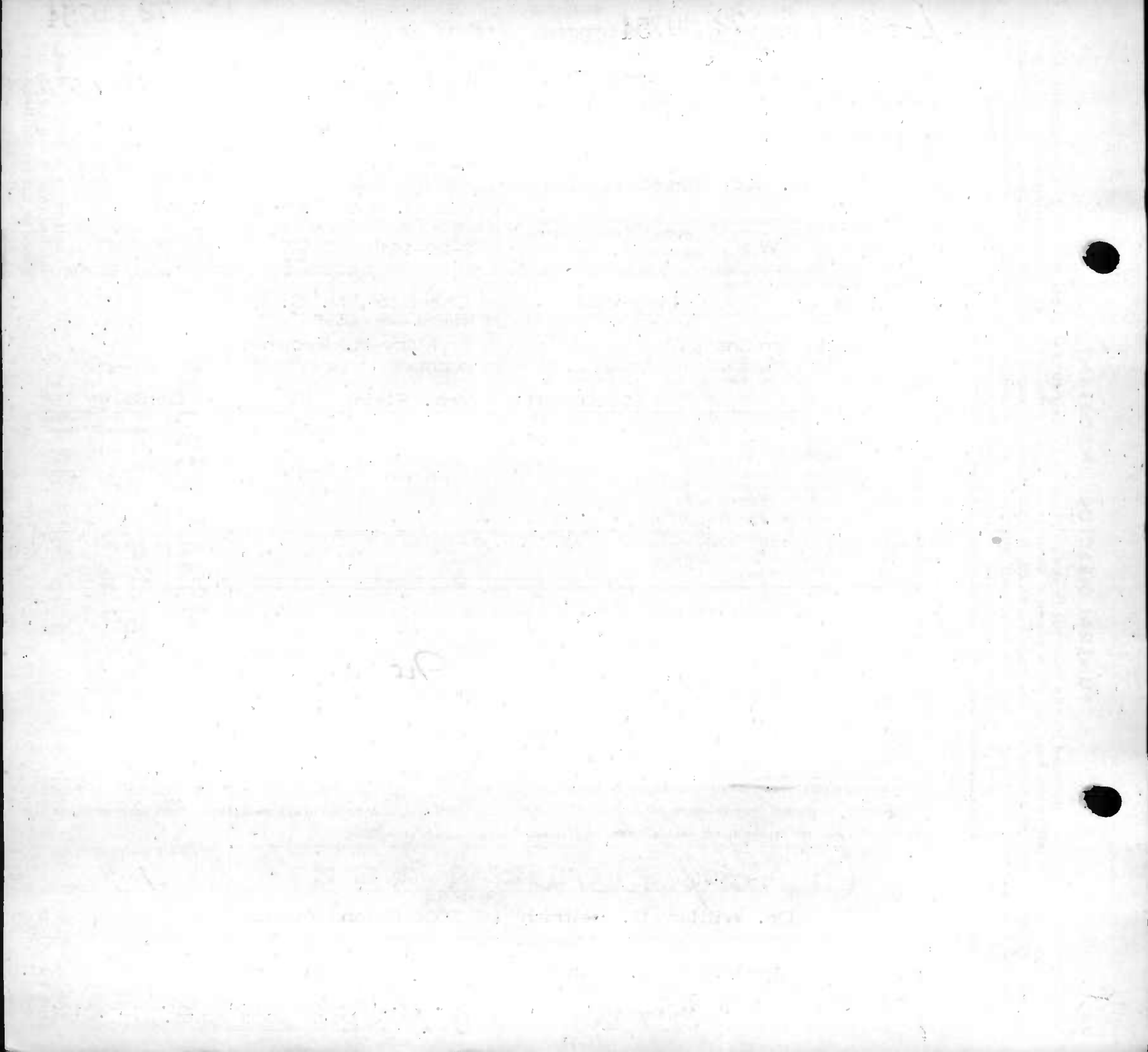




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

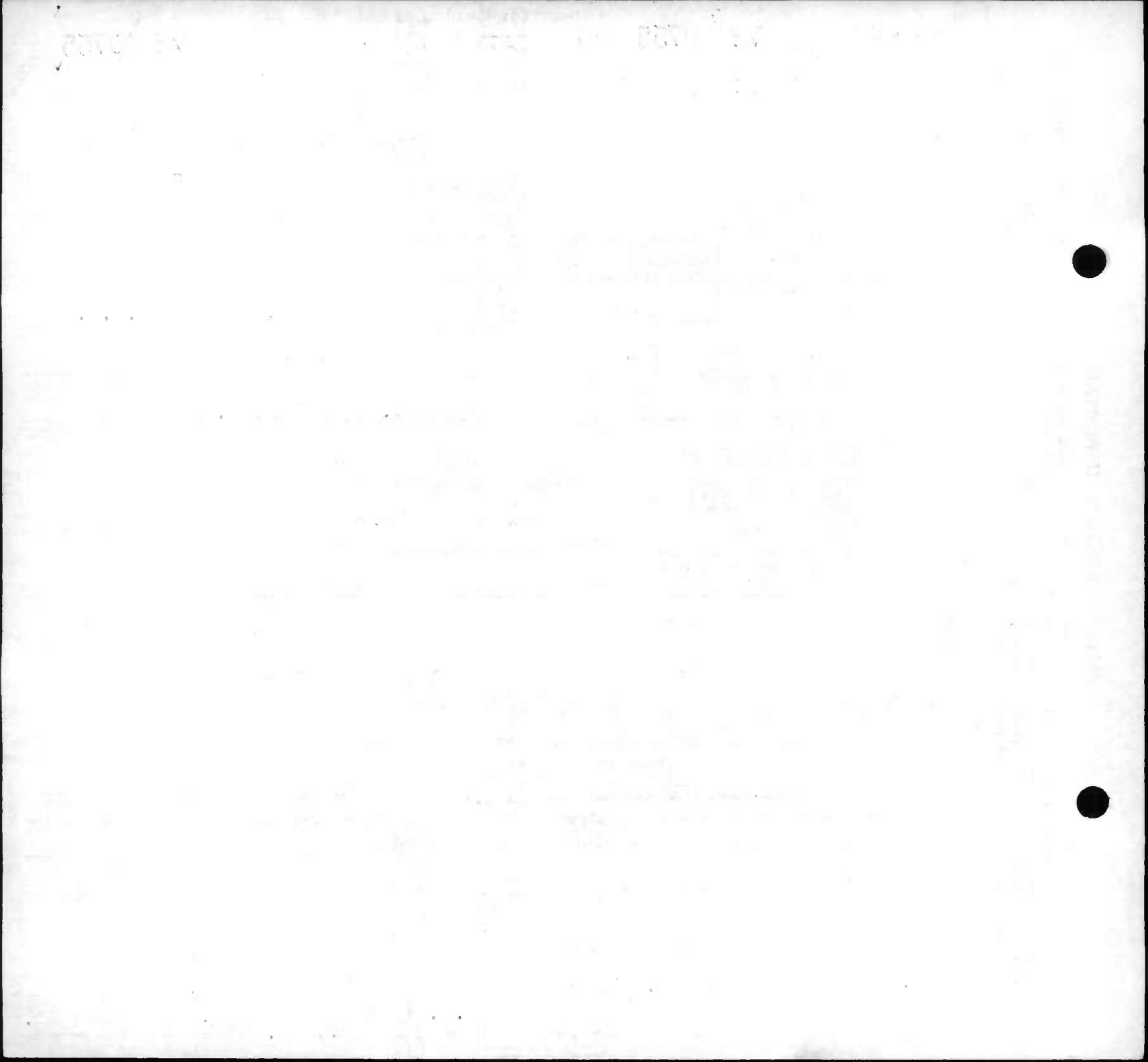
L-400		72 00754		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00754	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) Thomas Horace Bower Browne Lilly				2. DATE AND HOUR OF DEATH Jan. 20, 1972 3:15 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 622 W. 40th Street				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
5. SEX M		6. RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-29-1913	
9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		11. BIRTHPLACE (State or foreign country) Charlotte, N. C.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Austin Jenkins Lilly				14. MOTHER'S MAIDEN NAME Mary H. Browne			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 219-03-0411		17. INFORMANT Mrs. Elaine Lilly	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20A. AUTOPSY? (Yes or No) No 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner) 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/> 21F. HOW DID INJURY OCCUR? 22. I certify that (I) (this hospital) attended the deceased from Sept 22 1966 to Jan 20 1972 and that (I) (we) last saw the deceased alive on Jan 19 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. 23A. SIGNATURE Dr. William G. Helfrich M.D. 23B. DATE SIGNED 1-21-72 23C. PHYSICIAN'S NAME (Type) Dr. William G. Helfrich 23D. ADDRESS 5006 Roland Avenue 24A. BURIAL CREMATION, REMOVAL (Specify) Burial 24B. DATE 1-22-72 24C. NAME OF CEMETERY or CREMATORY St. John's 24D. LOCATION Long Green Md. 25A. DATE REC'D BY HEALTH DEPT. JAN 24 1972 25B. NAME OF REGISTRAR H. W. Jenkins & Sons Co. 25C. FUNERAL DIRECTOR ADDRESS 74905 York Road Balto., Md. 21212							



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

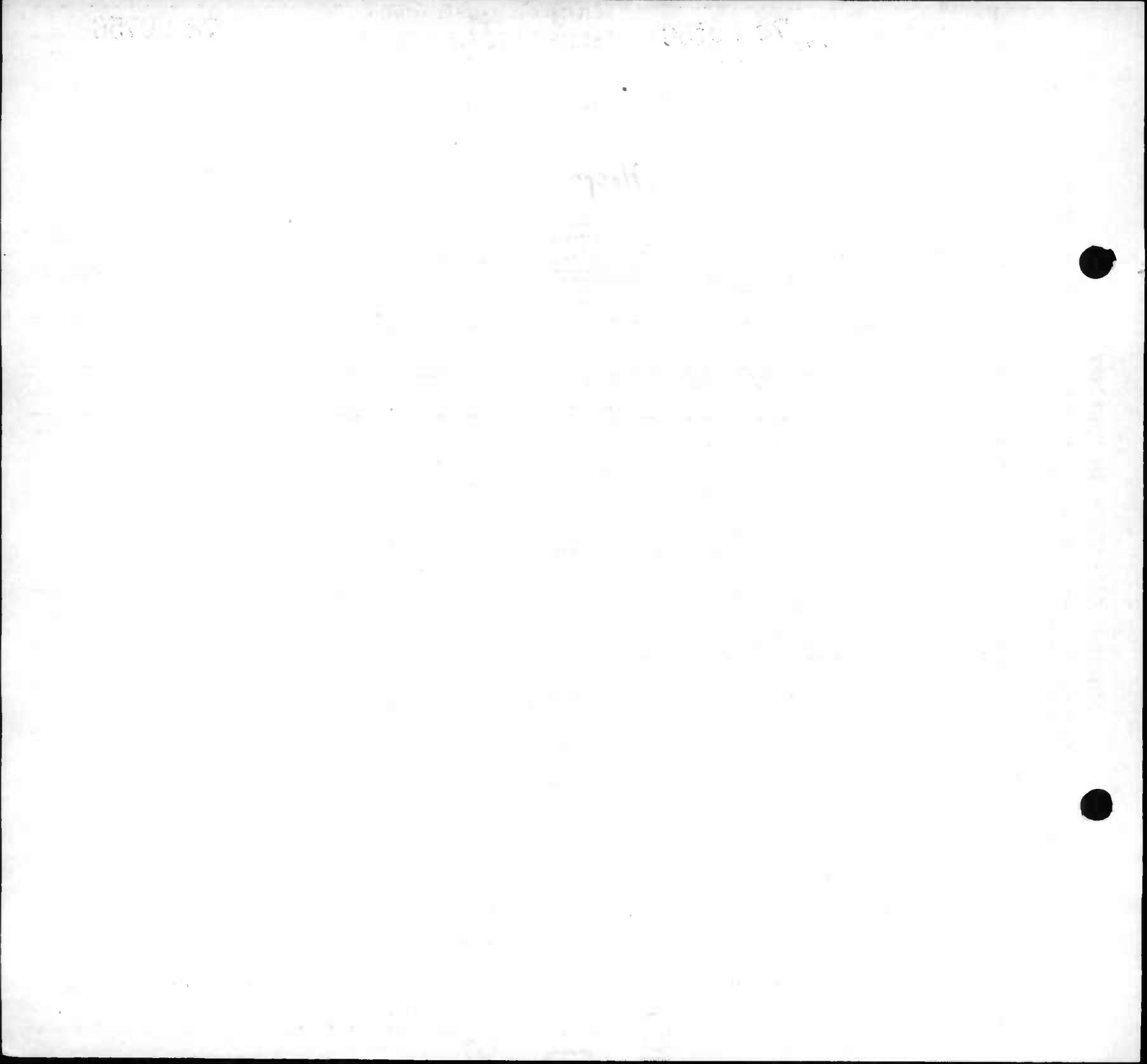
7-634 BIRTH NO. <i>Utah</i>		72 00755		BALTIMORE CITY HEALTH DEPARTMENT LLO. JR. JOSEPH E.		REG. NO. 72 00755	
1. NAME OF DECEASED (Type or Print) <b>FRATELLO, Joseph Edward III</b>				2. DATE AND HOUR OF DEATH <b>1-21-72 430AM M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>The Johns Hopkins Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Pennsylvania</b> B. COUNTY <b>York</b> C. CITY OR TOWN <b>York</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>199 Silver Spur Drive 17402</b>			
5. SEX <b>Male</b>	6. RACE <b>Cauc.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/6/67</b>	9. AGE (In years last birthday) <b>5</b>	If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION [Give kind of work done during most of working life, even if retired] <b>None</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>None</b>		11. BIRTHPLACE (State or foreign country) <b>Salt Lake City, Utah</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph E. Fratello, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Janet Shannon</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>Joseph E. Fratello, Jr. (Same)</b>			
18. CAUSE OF DEATH <b>I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>respiratory failure</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>shock lung</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>48 HRS</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Tetrolology of Fallot - 3/4 surgical correction</b>							
19A. DATE OF OPERATION <b>1-19-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>TETROLOGY of Fallot</b>		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <b>NO</b>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>INJURY OCCUR?</b>		(If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1-18 19 72</b> to <b>1-21 19 72</b> that (I) (we) last saw the deceased alive on <b>1-21 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Hugh Robinson MD</b>				23B. DATE SIGNED <b>1-21-72</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>Hugh Robinson, MD.</b>				23D. ADDRESS <b>The Johns Hopkins Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Rem. Burial</b>		24B. DATE <b>1/25/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Olivet</b>		24D. LOCATION (City, town, or county) (State) <b>Salt Lake City, Utah</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>H. W. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>H. W. Jenkins &amp; Sons Co. 4905 York Rd. Balt., Md. 21212</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 00756	
4-220		72 00756		CERTIFICATE OF DEATH	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>RAYMOND HUGHES</b>		2. DATE AND HOUR OF DEATH <b>1-21-72</b> <b>7<sup>15</sup> P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2711</b>			
FULL NAME OF HOSPITAL OR INSTITUTION <b>37</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Mercy Hosp.</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>MALE</b>		6. RACE <b>CAUCASIAN</b>		E. STREET AND NUMBER <b>2 Blythewood Rd. 21210</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>1-11-1882</b>		9. AGE (in years last birthday) <b>90</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Executive</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Jeweler</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>?</b>		14. MOTHER'S MAIDEN NAME <b>?</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-34-6747</b>		17. INFORMANT <b>Myrtle E. Hughes</b> ADDRESS <b>Same</b>	
18. <b>157.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> (A) IMMEDIATE CAUSE <b>CARCINOMA OF PANCREAS</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>SEPTICEMIA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/10</b> 19 <b>72</b> to <b>1/21</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/21</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Joann F. Joann</b>				23B. DATE SIGNED <b>1-22-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>JOAQUIN</b>		23D. ADDRESS <b>Mercy Hospital</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-24-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Woodlawn Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore, Co., Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>			
25B. NAME OF REGISTRAR <b>Henry W. Jenkins</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Henry W. Jenkins Sons 4905 York Rd. Baltimore, Md. 21212</b>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-630		72 00757		BALTIMORE CITY HEALTH DEPARTMENT		72 00757	
BIRTH NO.				CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <b>HARRY V. BERRETT, Sr.</b>				2. DATE AND HOUR OF DEATH <b>18 JAN 1972 10 40</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNIV. OF MARYLAND Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>HOWARD</b> C. CITY OR TOWN <b>ELKRIDGE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>5790 MAIN STREET</b> 21227			
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>9/21/05</b>	9. AGE (In years last birthday) <b>66</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Strescon Industries</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>WALTER F. BERRETT</b>				14. MOTHER'S MAIDEN NAME <b>D. CATHERINE BACH</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>545-01-4611</b>		17. INFORMANT ADDRESS <b>Mr. Harold L. Berrett, 6390 Loudon Ave. 21227</b>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Bronchogenic Carcinoma</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Repetitive Metastasis</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 mos</b> <b>1 mos</b>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>INappropriate ADH Secretion</b>							
19A. DATE OF OPERATION <b>12/6/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>BIOPSY LUNG MASS</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (the hospital) attended the deceased from <b>11/6/72</b> to <b>Jan 18 1973</b> that (4) (we) last saw the deceased alive on <b>Jan 18 1973</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
23A. SIGNATURE <b>D. C. ALEVIZATOS, M.D.</b>				23B. DATE SIGNED <b>19 Jan 72</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type) <b>D. C. ALEVIZATOS, M.D.</b>		23D. ADDRESS <b>1705 ST. Paul St</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-22-1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Wash. Blvd. Howard County, Md.</b>	
25A. DATE RECD BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b>		ADDRESS <b>4107 Wilkens Ave. 2127</b>	

ST 1000

ST 1000



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				CERTIFICATE OF DEATH		REG. NO. <u>72 00758</u>	
BIRTH NO. <u>A-140</u>		1. NAME OF DECEASED Type or Print <u>XXXXXX, Raymond L ABEL, SR.</u>		2. DATE AND HOUR OF DEATH <u>1-19-72</u> <u>10:40 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <u>37 MERCY HOSPITAL</u> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md</u> B. COUNTY <u>2864</u>			
5. SEX <u>M</u>		6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-13-10</u>	
9. AGE (In years last birthday) <u>61</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Engineers Aid</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Abel</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Wall</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes</u> <u>W W II</u>		16. SOCIAL SECURITY NO. <u>216-09-3449</u>		17. INFORMANT ADDRESS <u>Mrs. Madeline M. Abel, 4525 Pen Lucy Rd. 21229</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CARDIAC ARREST</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Arteriosclerotic cardiovascular disease</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>20 MINS</u>			
<div style="text-align: center;">II</div> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <u>1-19-72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR			
22. I certify that (1) (this hospital) attended the deceased from <u>1-18</u> 19 <u>72</u> to <u>1-19</u> 19 <u>72</u> and that (1) (we) lost saw the deceased alive on <u>1-19</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Aidan E. Walsh MD</u>				23B. DATE SIGNED <u>1-19-72</u>		23C. PHYSICIAN'S NAME (Type) <u>AIDAN E. WALSH MD</u>	
23D. ADDRESS <u>222 ST. PAUL, BALTO 2, MD.</u>							
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-22-1972</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1972</u>		25B. NAME OF REGISTRAR <u>Rebecca B. ...</u>		25C. FUNERAL DIRECTOR ADDRESS <u>Howard H. Hubbard, 4107 Wilkens Ave. 21229</u>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-416		72 00759		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00759	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Henry L. Silberzahn</u>				2. DATE AND HOUR OF DEATH <u>1/15/72</u> <u>7:10 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <u>Maryland Gen. Hosp.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Howard</u> <u>6300</u>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Maryland Gen. Hosp.</u>				C. CITY OR TOWN <u>Ellicott City</u>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u> 6. RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH <u>6/9/08</u>		9. AGE (in years last birthday) <u>63</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTH PLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Louis Silberzahn</u>			
14. MOTHER'S MAIDEN NAME <u>Nettie Fisher</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>216-03-8535</u>				17. INFORMANT <u>Mrs. Jeannette Silberzahn, 9786 Michaels Way</u>			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <u>Stroke</u> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last <u>Arteriosclerotic cardiovascular disease</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1/12</u> 19 <u>72</u> to <u>1/18</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/18</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Michael A. Silverman, M.D.</u>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <u>Michael A. Silverman, M.D.</u>	
23D. ADDRESS		23E. NAME OF REGISTRAR <u>Howard H. Hubbard, Jr.</u>		23F. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Avenue 21229</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-22-1972</u>		24C. NAME OF CEMETERY or CREMATORY <u>Loudon Park Cemetery</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1972</u>		25B. NAME OF REGISTRAR <u>Howard H. Hubbard, Jr.</u>		25C. FUNERAL DIRECTOR <u>Howard H. Hubbard, 4107 Wilkens Avenue 21229</u>			

0070 84

0070 84



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

T-460		72 00760		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00760	
1. NAME OF DECEASED (Type or Print) <b>TALLEY, FRANCIS</b>				2. DATE AND HOUR OF DEATH <b>JAN. 21. 1972</b>   <b>12</b> P. M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>39</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Provident Hospital</b> <b>2600 Liberty Heights Avenue</b> <b>Baltimore, Maryland 21215</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1504</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2124 Walbrook Avenue</b>					
5. SEX <b>Female</b>	6. RACE <b>Black</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/28/89</b>	9. AGE (in years last birthday) <b>82</b>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>Bernard Evans</b>				14. MOTHER'S MAIDEN NAME <b>Lucy Athey</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <b>CHARLES EVANS</b> ADDRESS <b>Same</b>			
18. <b>4-12-21</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CUA</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last, <b>HCV D.</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>11-27-1971</b> to <b>JAN 21 1972</b> that (I) <input checked="" type="checkbox"/> last saw the deceased alive on <b>JAN 21 1972</b> and that (in my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. (I) <input checked="" type="checkbox"/> (did) <input checked="" type="checkbox"/> (did not) view the body after death.									
23A. SIGNATURE <b>Rayman I. Ailly M.D.</b>				23B. DATE SIGNED <b>1/21/72</b>		23C. PHYSICIAN'S NAME (Type) <b>KAYMAN, I. Ailly M.D.</b>			
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-25-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Maryland National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>E. S. S. S. S.</b>		25C. FUNERAL DIRECTOR <b>Wilmington S. Phillips</b>		25D. ADDRESS <b>1727 N. Moore St.</b>			

007 57

007 57

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

G-355		BALTIMORE CITY HEALTH DEPARTMENT		72 00761	
72 00761		CERTIFICATE OF DEATH		REG. NO. 72 00761	
1. NAME OF DECEASED (Type or Print) <u>Goodman, James Willie Sr.</u>		2. DATE AND HOUR OF DEATH <u>1/23/72</u> <u>1:5 am</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>MONTEBELLO S.H.</u>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> <u>2788</u> C. CITY OR TOWN <u>Cuthbert</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>5328 Cathedral St 21216</u>			
5. SEX <u>Male</u>	6. RACE <u>Black</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-30-24</u>	9. AGE (In years last birthday) <u>47</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>North Carolina (USA)</u>	
12. CITIZEN OF WHAT COUNTRY? <u>(USA)</u>		13. FATHER'S NAME <u>George Goodman</u>		14. MOTHER'S MAIDEN NAME <u>Annie Bell Henderson</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Parrie L. Witherspoon</u> ADDRESS <u>1211 Guilmauff</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pulmonary Embolism</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Head trauma with intracerebral hemorrhage</u> <u>Pulmonary embolus</u> <u>Cranio-cerebral Injuries</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF: <u>probable hemorrhage was probable</u> (B) <u>Pulmonary embolus</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Cranio-cerebral Injuries</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>8 months</u> <u>11 hours</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>1-21-71</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Subdural Hematoma</u>		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input checked="" type="checkbox"/>			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <u>Street</u>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>Reisterstown Rd. &amp; Hayward Ave 27-88</u>			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>1-16-71</u>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <u>Fell on street &amp; struck head</u>	
22. I certify that (I) (this hospital) attended the deceased from <u>6-22-1971</u> to <u>1-23-1972</u> and that (I) (we) last saw the deceased alive on <u>1-23-1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Frederick Pearson, MD</u>		23B. DATE SIGNED <u>23 JAN 72</u>		23C. PHYSICIAN'S NAME (Type) <u>FREDERICK PEARSON MD</u>	
23D. ADDRESS <u>MONTEBELLO S.H.</u>		24A. BURIAL CREMATION, REMOVAL (Specify) <u>Removal</u>			
24B. DATE <u>1-25-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Evergreen</u>		24D. LOCATION (City, town, or county) (State) <u>Winston Salem N.C.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 24 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, Jr.</u>		25C. FUNERAL DIRECTOR <u>William J. Kelly</u> ADDRESS <u>1727 N. Moody</u>	

1870-89

1870-89



W-452

72 00762

BALTIMORE CITY HEALTH DEPARTMENT

72 00762

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Robert J. Williams, Jr.</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>1</b> Day <b>18</b> Year <b>72</b>		Hour
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>1</b> Day <b>18</b> Year <b>72</b>		Hour <b>1:52 p.</b>
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b>				
6. SEX <b>male</b>	7. RACE <b>White</b>	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto. Highlands</b>
9. DATE OF BIRTH <b>4-23-1945</b>		10. AGE (In years last birthday) <b>26</b>	E. STREET AND NUMBER <b>2904 Virginia Avenue</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Robert J. Williams, Sr.</b>
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Truck Driver</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>United Oil Co.</b>		15. MOTHER'S MAIDEN NAME <b>Charlotte E. Pease</b>
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes 1964-1969</b>		17. SOCIAL SECURITY NO. <b>212-44-9611</b>	18. INFORMANT <b>Mr. Robert J. Williams, Sr.</b>	
		ADDRESS <b>21227 2904 Virginia Ave</b>		
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>2464 Congenital heart disease (intra atrial septal defect)</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
		(B) DUE TO, OR AS A CONSEQUENCE OF:		
		(C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>1/19/72</b> EXAMINER'S NAME (Type)				
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-21-1972</b>	24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Wash. Blvd. Howard Co., Md.</b>				
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Avenue</b>
		ADDRESS <b>21229</b>		

X

Robert E. Williams, Jr.

Charles E. Evans

Mr. Robert E. Williams, Jr.

Mr. Charles E. Evans

*[Handwritten signature]*

38-10782

Robert E. Williams, Jr.  
Charles E. Evans

H-200

72 00763

BALTIMORE CITY HEALTH DEPARTMENT

72 00763

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) William F. Haake		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour 1 17 72 10:00A. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 529 S. Brunswick Avenue		3. DATE PRONOUNCED DEAD Month Day Year Hour 1 17 72 10:00A. M.	
6. SEX Male		7. RACE White	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 10-1-1896		10. AGE (in years last birthday) 75 <del>XX</del>	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		15. MOTHER'S MAIDEN NAME Mitilda Hoose	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No		17. SOCIAL SECURITY NO. 216-44-4549	
18. INFORMANT Mrs. Frances E. Haake, 529 S. Brunswick St.		ADDRESS 21223	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> - Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE EXAMINER'S NAME (Type) Werner U. Spitz, M.D. DATE SIGNED 1-18-72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-21-1972	
24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.	
25C. FUNERAL DIRECTOR		ADDRESS Howard H. Hubbard, 4107 Wilkens Ave. 21229	

6270-5572

NS 11503

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00764	
BIRTH NO. 72 00764		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) DIEHLMANN, PAMPLIN ESTELLE		2. DATE AND HOUR OF DEATH JANUARY 18, 1972 9:30 P. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE	
FULL NAME OF HOSPITAL OR INSTITUTION ST AGNES HOSPITAL CATON & WILKENS AVENUES BALTIMORE, MARYLAND 21229		C. CITY OR TOWN BALTIMORE	
D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		E. STREET AND NUMBER 4763 BELWOOD GREEN	
5. SEX FEMALE	6. RACE CAUCASIAN	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 02/04/99
9. AGE (In years last birthday) 72		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE	
11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME JAMES NEWTON		14. MOTHER'S MAIDEN NAME ANNIE COOK	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-22-3821	
17. INFORMANT BALTO MD 21229 ST AGNES' RECORDS CATON & WILKENS AVES		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk. 2 yrs. 5 days	
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20. MEDICAL CERTIFICATION 20A. DATE OF OPERATION 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED 20C. AUTOPSY? (Yes or No) 20D. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? 20E. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) 20F. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) 20G. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) 20H. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 20I. HOW DID INJURY OCCUR?			
21. I certify that (X) (this hospital) attended the deceased from JANUARY 18 19 72 to JANUARY 18 19 72 that (X) (we) last saw the deceased alive on JANUARY 18 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.			
22. SIGNATURE HARJIT SINGH M.D. HARJIT SINGH M.D.		23. DATE SIGNED 1/18/72	
24. PHYSICIAN'S NAME (Type) HARJIT SINGH M.D.		25. ADDRESS ST- AGNES HOSPITAL BALTO.	
26. BURIAL CREMATION, REMOVAL (Specify) Burial		27. DATE 1-21-72	
28. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery		29. LOCATION Baltimore, Maryland	
30. DATE REC'D BY HEALTH DEPT. JAN 24 1972		31. NAME OF REGISTRAR Valerie L. Taylor, R.D.	
32. FUNERAL DIRECTOR Howard H. Hubbard, 4107 Wilkens Ave. 21229		ADDRESS	

ROYAL

1917

1917

1917

1917

1917

1917

1917

1917

W-640

72 00765 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00765

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>Louis Worrel</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 21 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>43 So. Balto. Gen. Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 21 72 7:45 P.M.</b>	
6. SEX <b>male</b>		7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>4/8/08</b>		10. AGE (In years last birthday) <b>63</b>	
11. BIRTHPLACE (State or foreign country) <b>Washington D.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jesse F. Worrel</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Shipping Clerk</b>	
15. MOTHER'S MAIDEN NAME <b>Ethel M. Waller</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO. <b>213-05-1876</b>		18. INFORMANT ADDRESS <b>Louis Worrel Jr. -----</b>	
19. <b>412.4</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Arteriosclerotic cardiovascular disease</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (Minute) <b>1 21 72 7 45</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/22/72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/25/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Cedar Hill Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Kelly</b>	
25C. FUNERAL DIRECTOR <b>McCully Funeral Homes</b>		25D. ADDRESS <b>130 E. Font Ave.</b>	



25 00562

25 00562

Page 1 of 1

0.00000000

0.00000000

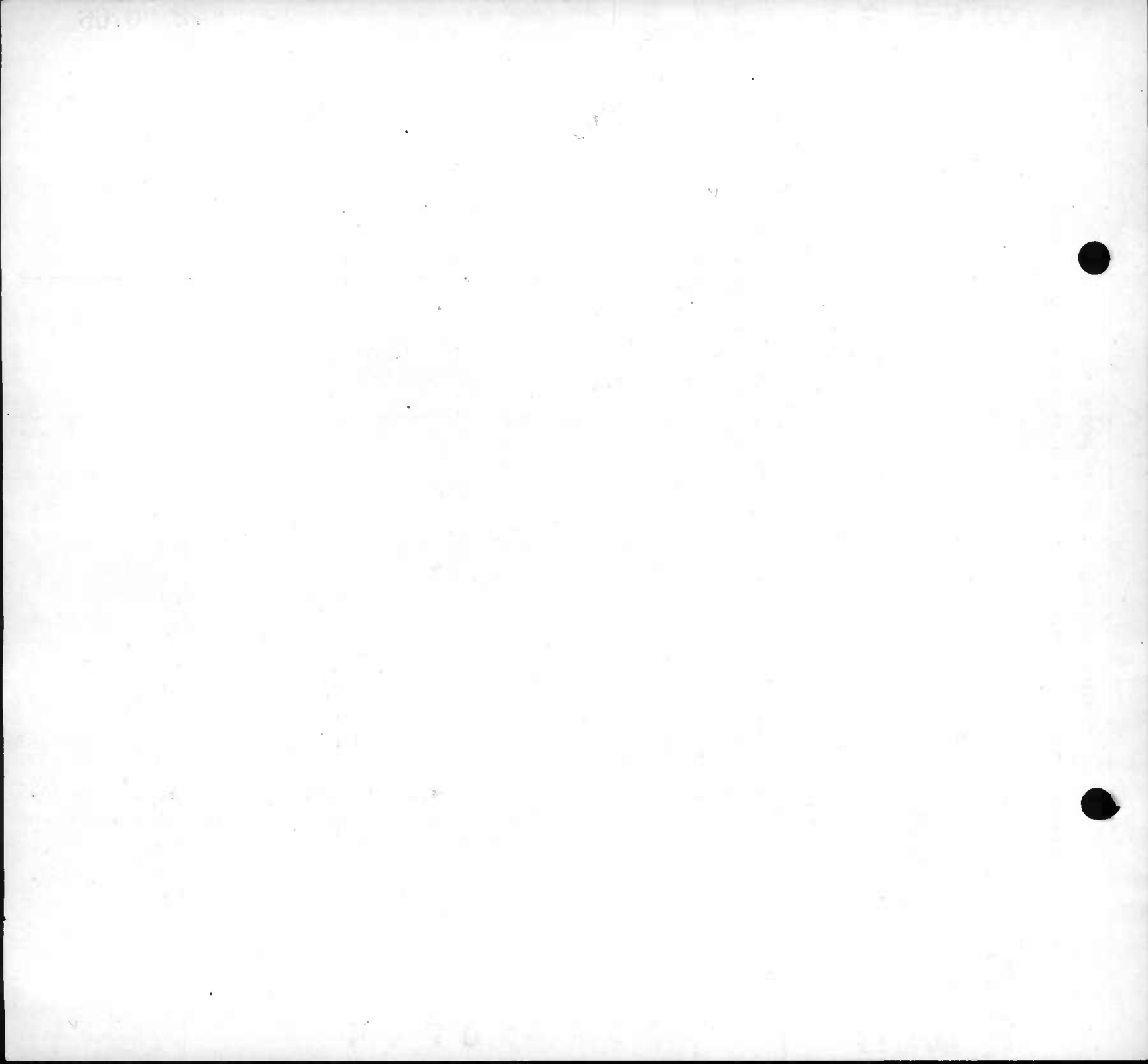




**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

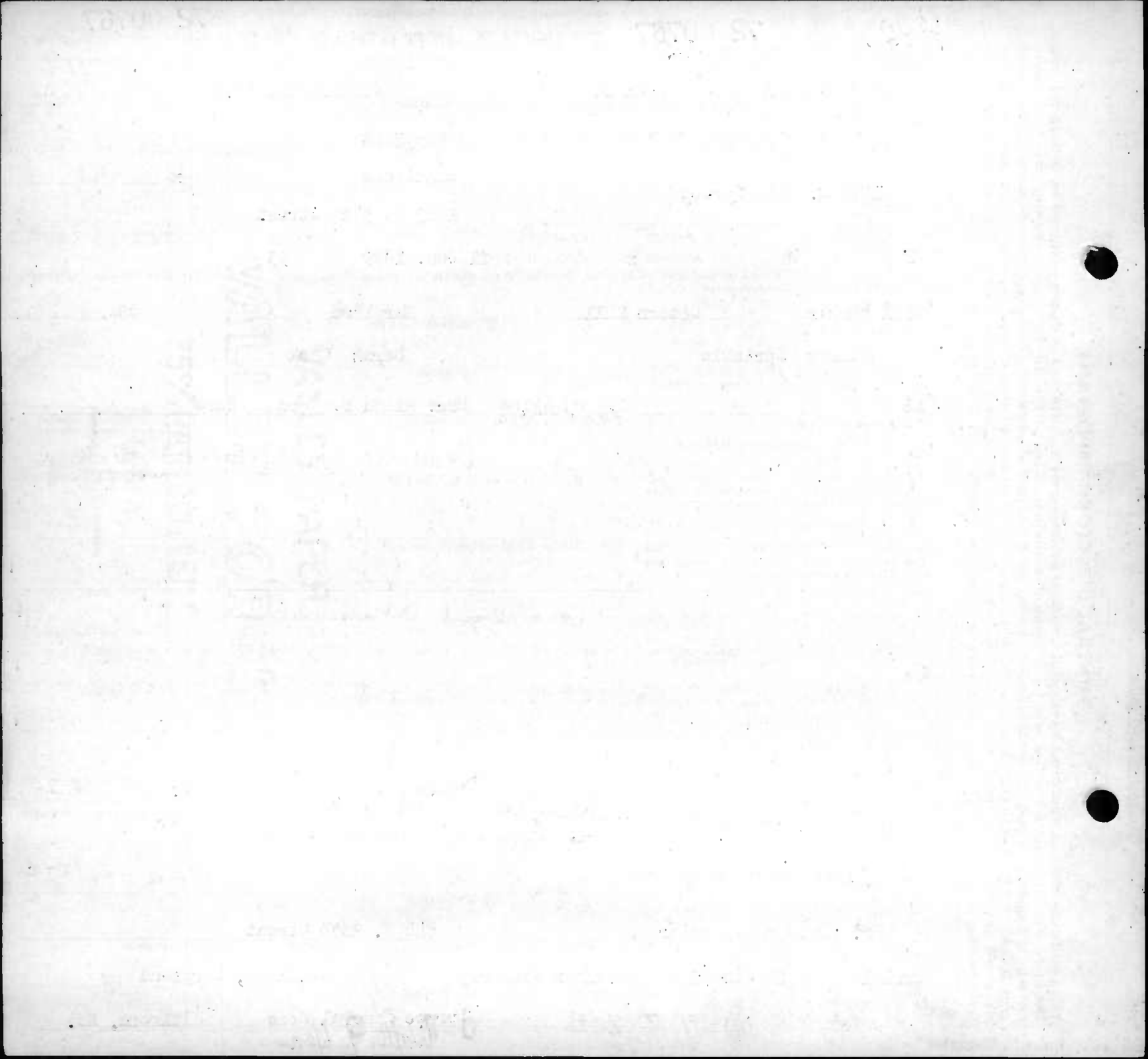
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.5em;">72 00766</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">R-452</span>		<span style="font-size: 1.5em;">72 00766</span>		<b>CERTIFICATE OF DEATH</b>	
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.2em;">George Ruehling</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.2em;">1/20/72</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <span style="font-size: 1.2em;">00 18 Bristol Ave</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Md.</span> B. COUNTY <span style="font-size: 1.5em;">2534</span>  <b>C. CITY OR TOWN</b> <span style="font-size: 1.2em;">Baltimore</span>  <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  <b>E. STREET AND NUMBER</b> <span style="font-size: 1.2em;">18 Bristol Ave</span>		
<b>5. SEX</b> <span style="font-size: 1.2em;">M</span>	<b>6. RACE</b> <span style="font-size: 1.2em;">White</span>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.2em;">6/24/1896</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.2em;">75</span>	<b>If Under 1 Yr.</b> Months: Days: <b>If Under 24 Hrs.</b> Hours: Min.
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Bait Store</span>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.2em;">Self Employed</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.2em;">Md.</span>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.2em;">USA</span>			<b>13. FATHER'S NAME</b> <span style="font-size: 1.2em;">Agust Ruehling</span>		
<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.2em;">Wilhelmeria Vogel</span>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">no</span>		
<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.2em;">213 05 5384</span>			<b>17. INFORMANT</b> <span style="font-size: 1.2em;">Alice M. Ruehling</span>		
<b>18. 492X I</b> <b>CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">Coronary occlusion</span> DUE TO, OR AS A CONSEQUENCE OF: (B) <span style="font-size: 1.2em;">hypertensive cardiovascular disease</span> DUE TO, OR AS A CONSEQUENCE OF: (C) <span style="font-size: 1.2em;">emphysema</span>			<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>		
<b>II</b>					
<b>MEDICAL CERTIFICATION</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.2em;">Jan 20 1972</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">Jan 17</span> 1971 to <span style="font-size: 1.2em;">Jan 20</span> 1972, that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">Jan 20</span> 1972 and that in (my) (our) opinion, death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.2em;">Philip M. Keister</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.2em;">Jan 22 72</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.2em;">KEISTER</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.2em;">302 Patapsco Ave Balto 25</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.2em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.2em;">1/24/72</span>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <span style="font-size: 1.2em;">Glen Haven Cemetery</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.2em;">Glen Burnie Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.2em;">JAN 24 1972</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.2em;">J. E. J. J. J.</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.2em;">McCully Funeral Home 2376 Patapsco Ave</span>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-420 72 00767				BALTIMORE CITY HEALTH DEPARTMENT		72 00767	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Lillian May Pollock				January 21, 1972 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
00 1223 W. 37th Street				Maryland 1348			
5. SEX F 6. RACE W 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 21 Jan. 1879		9. AGE (In years last birthday) 93	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mill Worker				10B. KIND OF BUSINESS OR INDUSTRY Cotton Mill		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME Thomas Sprinkle				14. MOTHER'S MAIDEN NAME Sarah Cook			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. 213 03 4310A		17. INFORMANT Mrs. Hilda M. Ford Same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Cerebral Vascular Accident 5 days	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				Generalized Atherosclerosis			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from July 1964 to JAN 21 1972, that (I) (we) last saw the deceased alive on JAN 20 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Sheldon Goldgeier				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED JAN 22, 1972	
23C. PHYSICIAN'S NAME (Type) Dr. Sheldon Goldgeier				23D. ADDRESS 848 W. 36th Street			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 24 Jan 72		24C. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		24D. LOCATION (City, town, or county) (State) Woodlawn, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1972		25B. NAME OF REGISTRAR Walter E. Jones		25C. FUNERAL DIRECTOR Bungee Funeral Home		ADDRESS Baltimore, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-360		72 00768		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00768	
1. NAME OF DECEASED (Type or Print) J. LEONARD STARR				2. DATE AND HOUR OF DEATH 11/19/72 10 <sup>45</sup> P M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 44 UNION MEMORIAL HOSPITAL				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Md. B. COUNTY 2755			
5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 1/23/13		9. AGE (in years, last birthday) 78	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED				10B. KIND OF BUSINESS OR INDUSTRY Plasterer		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY USA				13. FATHER'S NAME <del>UNKNOWN</del> James STARR			
14. MOTHER'S MAIDEN NAME <del>UNKNOWN</del> Mary MACNAMARA				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			
16. SOCIAL SECURITY NO. 218 09 8185				17. INFORMANT Helen C STARR			
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). CHRONIC RENAL FAILURE				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 2		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <input checked="" type="checkbox"/>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 11/11/72 19 to 11/19/72 19 that (I) (we) last saw the deceased alive on 11/11/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Ramon J. Busta MD				23B. DATE SIGNED 11/19/72		23C. PHYSICIAN'S NAME (Type) RAMON J. BUSTO MD	
23D. ADDRESS UNION MEMORIAL HOSPITAL				23E. FUNERAL DIRECTOR Burgess Funeral Home Balto Md		23F. ADDRESS By Harold M. Burgess Jr	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 22 JAN 72		24C. NAME of CEMETERY or CREMATORY Druid Ridge Cem		24D. LOCATION (City, town, or county) (State) Pikesville Balto Co Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 24 1972		25B. NAME OF REGISTRAR Robert E. Johnson		25C. FUNERAL DIRECTOR Burgess Funeral Home Balto Md		25D. ADDRESS By Harold M. Burgess Jr	

1. The first of these is the fact that the

the second of these is the fact that the

the third of these is the fact that the

the fourth of these is the fact that the

the fifth of these is the fact that the

the sixth of these is the fact that the

the seventh of these is the fact that the

the eighth of these is the fact that the

the ninth of these is the fact that the

the tenth of these is the fact that the

the eleventh of these is the fact that the

the twelfth of these is the fact that the

the thirteenth of these is the fact that the

the fourteenth of these is the fact that the

the fifteenth of these is the fact that the

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 00769		BALTIMORE CITY HEALTH DEPARTMENT		72 00769	
1. NAME OF DECEASED (Type or Print) <b>HELEN M. GILLESPIE</b>		2. DATE AND HOUR OF DEATH <b>1/23/1972 8:30 PM.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD <b>CHURCH HOME &amp; HOSPITAL</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND - 21224</b> B. COUNTY <b>602</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>CHURCH HOME &amp; HOSPITAL</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>123 - N. BELNORD AVENUE</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-4-93</b>	9. AGE (In years last birthday) <b>79 Yrs</b>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOME MAKER</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <b>JAMES GILESPIE</b>		14. MOTHER'S MAIDEN NAME <b>Katherine FRANK</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>215-07-8862</b>		17. INFORMANT <b>PAUL GILLESPIE SAN BERNARDINO CALIF.</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the manner of dying, e.g., heart failure, asphyxiation, etc., but the disease, injury or complication which means the disease, injury or complication caused death.) <b>NO CEREBRO VASCULAR ACCIDENT.</b>		CAUSE OF DEATH <b>NO CEREBRO VASCULAR ACCIDENT.</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>BASILAR ARTERY DISEASE</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)		URINARY TRACT INFECTION		HEPATIC INSUFFICIENCY; MULTIPLE BED SORES.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>12/23/71</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>FRacture HIP</b>		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>STREET</b>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>STREET?</b>	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <b>11/23/71</b>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <b>FALL AT A STREET.</b>	
22. I certify that (I) (this hospital) attended the deceased from <b>11/23/1971</b> to <b>1/23/1972</b> and that (I) (we) last saw the deceased alive on <b>1/23/1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>K. George Thomas M.D.</b>		23B. DATE SIGNED <b>1/23/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>K. GEORGE THOMAS MD</b>		23D. ADDRESS <b>CHURCH HOME &amp; HOSPITAL.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-26-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Holy Redeemer Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore Md.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 24 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. [illegible]</b>		25C. FUNERAL DIRECTOR <b>BRAD BROUSKI 2814 E. BALTIMORE ST.</b>	

1957

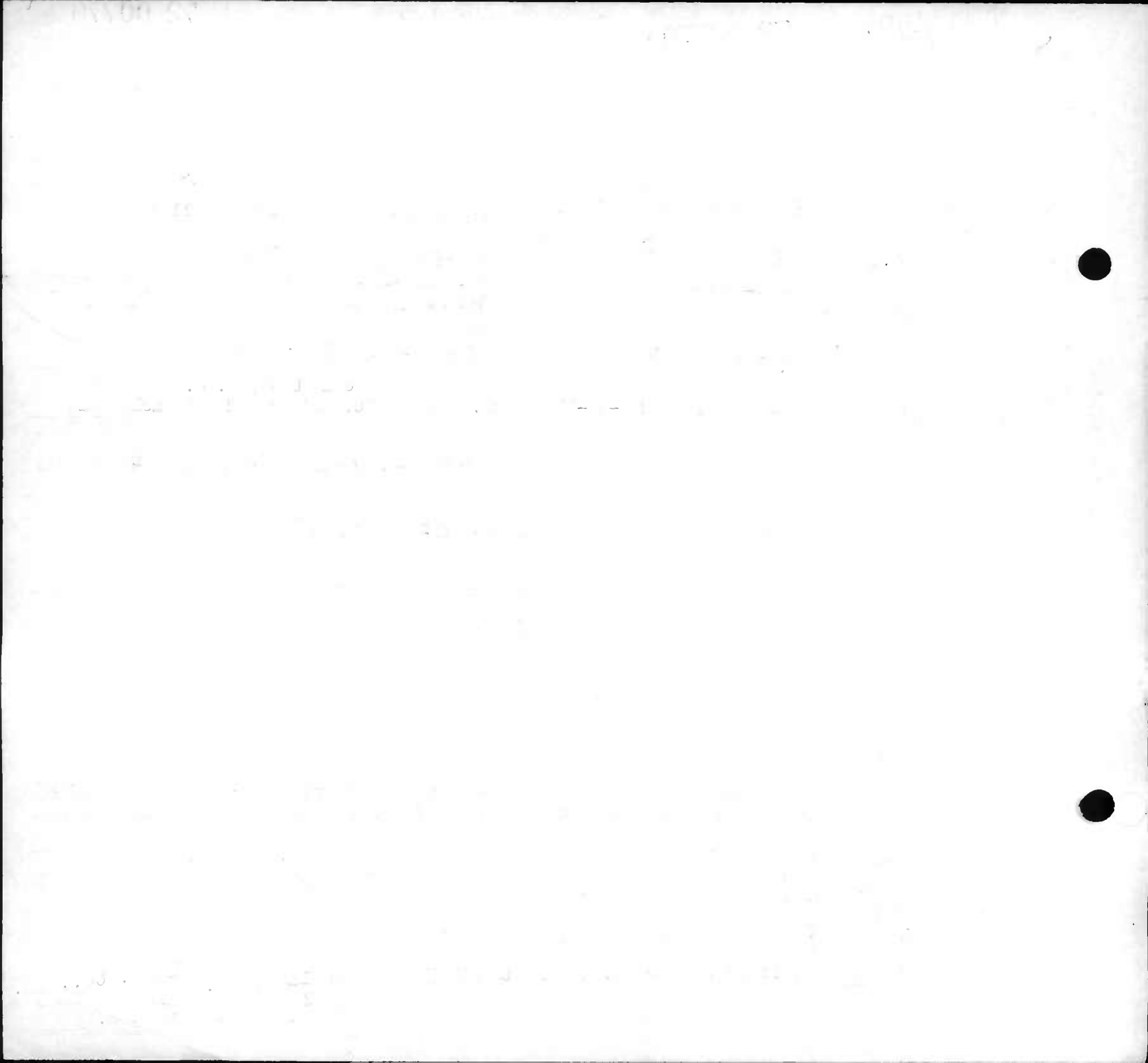
255 256



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 10-420		72 00770		BALTIMORE CITY HEALTH DEPARTMENT		72 00770	
1. NAME OF DECEASED (Type or Print) WAILES, RENA R.				2. DATE AND HOUR OF DEATH JAN-20 <sup>th</sup> - 1972 10.00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE NEW JERSEY B. COUNTY V27			
FULL NAME OF HOSPITAL OR INSTITUTION 44 THE UNION MEMORIAL HOSPITAL				C. CITY OR TOWN OCEAN CITY		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 126 PINNACLE ROAD		08226	
5. SEX FEMALE	6. RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 03-15-93	9. AGE (In years last birthday) 78	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? AMERICAN
13. FATHER'S NAME JOHN W. ROMAN (D)				14. MOTHER'S MAIDEN NAME EMMA GREGORY			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No None		16. SOCIAL SECURITY NO. 216-46-3390		17. INFORMANT Ocean City, N. J. ADDRESS 9 Mr. Theodore C. Wailes 126 Pinnacle Road			
18. 153.8 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: MYOCARDIAL INFARCTION 40 MINUTES (B) CARCINOMA OF COLON. DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 40 MINUTES	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). ANGINA PECTORIS							
19A. DATE OF OPERATION 11-17-72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED C2. OF COLON		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 1-15-1972 to 1-20-1972 that (I) (we) last saw the deceased alive on 1-20-1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Juan H. Finney R.D.				23B. DATE SIGNED 1-20-1972			
23C. PHYSICIANS NAME (Type) GEORGE FINNEY JR. H.D.				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/22/1972		24C. NAME OF CEMETERY OR CREMATORY LORRAINE PARK CEMETERY		24D. LOCATION (City, town, or county) (State) Woodlawn, Md. Balto. Co., Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1972		25B. NAME OF REGISTRAR Robert E. Taylor, M.D.		25C. FUNERAL DIRECTOR Loring Byers		25D. ADDRESS 8728 Liberty Road 21133 Funeral Directors, P. A.	



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00771'

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Milton J. Mason</b>		2. DATE OF DEATH Known <input type="checkbox"/> Estimated <input type="checkbox"/> Month <b>1</b> Day <b>18</b> Year <b>72</b> Hour <b>M.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 Balto. City Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>1</b> Day <b>18</b> Year <b>72</b> Hour <b>12:13 p.</b> M.	
6. SEX <b>male</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>1/3/04</b>		10. AGE (In years lost birthday) <b>68</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer - retired</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Beth. Steel</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		17. SOCIAL SECURITY NO. <b>-</b>	
18. INFORMANT <b>John C. Spedden (brother-in-law)</b>		ADDRESS <b>3604 Elkader Rd. 21218</b>	
19. <b>571.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>Cirrhosis of liver</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE: <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/22/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>Parkwood Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Ronald N. Kornblum</b>	
25C. FUNERAL DIRECTOR <b>Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto. Md. 21213</b>		ADDRESS	

17780 33

17780 33

17780 33

17780 33

17780 33

17780 33

17780 33

17780 33

17780 33

17780 33

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-500		72 00772		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00772	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) FEENEY, BARTHOLOMEW A.		2. DATE AND HOUR OF DEATH JANUARY 22, 1972 2:30 A. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		5300			
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
		E. STREET AND NUMBER 5542 SELMA AVENUE		21227			
5. SEX MALE	6. RACE CAUCASIAN	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 05-03-04	9. AGE (in years last birthday) 67	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) STEAMFITTER		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND, Cumberland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME BARTHOLOMEW FEENEY		14. MOTHER'S MAIDEN NAME MARY M.					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) YES WW I		16. SOCIAL SECURITY NO. 705-05-2023		17. INFORMANT CATON AVES-BALTO; MD ADDRESS 21229 ST AGNES HOSPITAL RECORDS-WILKENS &			
18. 441.2 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: cardiac arrhythmia (B) acute renal failure (C) ruptured abd. aortic aneurysm		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes 10 days 10 days			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 1/12/72		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ruptured aortic aneurysm		20A. AUTOPSY? (Yes or No) no		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that XX (this hospital) attended the deceased from JANUARY 12 19 72 to JANUARY 22 19 72 that X (we) last saw the deceased alive on JANUARY 22 19 72 and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. XX (We) (did) (did not) view the body after death.							
23A. SIGNATURE C. R. Chaney		23B. DATE SIGNED 1/22/72		23C. PHYSICIAN'S NAME (Type) C. R. CHANEY, M.D.			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/25/72		24C. NAME OF CEMETERY or CREMATORY Lake View Memorial Park		24D. LOCATION (City, town, or county) (State) Sykesville, Carroll, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1972		25B. NAME OF REGISTRAR R. E. J. J. J. J.		25C. FUNERAL DIRECTOR Loring Byers Funeral Directors 8228 Liberty Rd. Randallstown, Md. 21133			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>4-160</b>		72 00773		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <b>72 00773</b>	
1. NAME OF DECEASED (Type or Print) <b>HOOVER, ALICE Leshner</b>				2. DATE AND HOUR OF DEATH <b>1-19-72 3:40 pm</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE JOHNS HOPKINS HOSPITAL</b> <b>33</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>PENNSYLVANIA</b> B. COUNTY <b>V 35</b> C. CITY OR TOWN <b>WAYNESBORO</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>R D # 3</b>					
5. SEX <b>FEMALE</b>		6. RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <b>4-5-14</b>		9. AGE (In years last birthday) <b>57</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Daniel L. LESHNER</b> <b>G.H.</b>				14. MOTHER'S MAIDEN NAME <b>ORA Downey</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>188-09-5063</b>		17. INFORMANT <b>Mrs. William A. Sands, 2107 Trafalgar Dr. Owon Hill Md.</b>			
18. <b>150X I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cardiac and Respiratory arrest</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Chronic and acute Aspiration</b> DUE TO, OR AS A CONSEQUENCE OF: (C) <b>Carcinoma of the Esophagus</b>					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>2/2/72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Esophagus</b>		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>1/17</b> 19 <b>72</b> to <b>1/19</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/19</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>E. C. Holmes</b>				23B. DATE SIGNED <b>1/19/72</b>				23C. PHYSICIAN'S NAME (Type) <b>E. C. HOLMES</b>	
23D. ADDRESS <b>THE JOHNS HOPKINS HOSPITAL</b>									
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Green Hill</b>		24D. LOCATION (City, town, or county) (State) <b>Waynesboro, Franklin Co., Pa.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Jones, Jr.</b>		25C. FUNERAL DIRECTOR <b>Darby &amp; Grove</b>		ADDRESS <b>Waynesboro Pa.</b>			





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

L-200 <span style="float: right;">72 00774</span>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">72 00774</span>	
BIRTH NO.			1. NAME OF DECEASED (Type or Print) <u>Lewis, Albert</u>		
2. DATE AND HOUR OF DEATH <u>January 20, 1972</u> <u>9:45 A.M.</u>			3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>1538</u>			FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>39</u> <u>Provident Hospital Complex</u> <u>2600 Liberty Heights Ave.</u> <u>Baltimore, Maryland 21215</u>		
5. SEX <u>Male</u>		6. RACE <u>Black</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <u>1/1/11</u>		9. AGE (In years last birthday) <u>61</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>Albert Lewis</u>			14. MOTHER'S MAIDEN NAME <u>Josephine</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-01-3068</u>		17. INFORMANT <u>Mrs. Georgia Lewis-</u>	
18. <u>269-91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pneumonitis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Malnutrition</u> <u>Dehydration</u>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pneumonitis</u> (B) <u>Malnutrition</u> (C) <u>Dehydration</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>3:15 pm Jan. 16, 1972</u> to <u>9:45 AM Jan. 20, 1972</u> that (I) (we) last saw the deceased alive on <u>January 19, 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>Lewis B. Boone, M.D.</u> DEGREE				23B. DATE SIGNED <u>Jan. 20, 1972</u>	
23C. PHYSICIAN'S NAME (Type) <u>Lewis B. Boone, M.D.</u> DEGREE		23D. ADDRESS <u>Provident Hospital Baltimore, Md.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/25/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>MT Calvary Cemetery</u>	
24D. LOCATION <u>A A County Md</u>		24E. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1972</u>			
25A. NAME OF REGISTRAR <u>Robert E. Tully, M.D.</u>		25B. FUNERAL DIRECTOR <u>Adolphus Halstead</u>		25C. ADDRESS <u>1206 W 4th A</u>	



## 72 00775 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00775

BIRTH NO.

1. NAME OF DECEASED (Type or Print) MARGARET CLARK		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour January 19, 1972 9:27 P. M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 39 Provident Hospital		3. DATE PRONOUNCED DEAD Month Day Year Hour January 19, 1972 9:27 P. M.	
6. SEX Female		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH 222 60		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) 60		E. STREET AND NUMBER 2411 Etings Street	
11. BIRTHPLACE (State or foreign country) Washington, D C		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Anderson Lilly		14. MOTHER'S MAIDEN NAME Ethel	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		16. KIND OF BUSINESS OR INDUSTRY	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		18. SOCIAL SECURITY NO.	
19. 412.4 I		20. INFORMANT ADDRESS Mr Samuel Lilly, 1405 McCulloh St	
21. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) Arteriosclerotic cardiovascular disease ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
22. DATE OF OPERATION 2		23. CONDITION FOR WHICH OPERATION WAS PERFORMED	
24. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		25. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
26. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)		27. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
28. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		29. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Charles S. Springate M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) Charles S. Springate, M.D.		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>	
		ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED January 20, 1972	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/72	
24C. NAME OF CEMETERY or CREMATORY MT Calvary Cemetery		24D. LOCATION (City, town, or county) (State) A A County Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1972		25B. NAME OF REGISTRAR Robert E. Taylor M.D.	
25C. FUNERAL DIRECTOR Adolphus Halstead		25D. ADDRESS 1206 W North St	

SS 00175

SS 00175 MEDICAL EXAMINER CERTIFICATE OF DEATH

NAME OF DECEASED

DATE OF DEATH

AGE OF DECEASED

PLACE OF DEATH

SEX OF DECEASED

CAUSE OF DEATH

DATE OF EXAMINATION

TIME OF EXAMINATION

PLACE OF EXAMINATION

INITIALS

NAME OF PHYSICIAN

NAME OF MEDICAL EXAMINER

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

NAME OF WITNESS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1

<p><b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b></p>		<p>72 00776</p>	
<p>BIRTH NO. <u>4-520</u></p>		<p>REG. NO. <u>72 00776</u></p>	
<p>1. NAME OF DECEASED (Type or Print) <u>HAINES, HOWARD</u></p>		<p>2. DATE AND HOUR OF DEATH <u>JAN. 22, 1972</u> <u>6:30 P.</u> M.</p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <u>ANDERSON NURSING HOME</u></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u></p>	
<p>FULL NAME OF HOSPITAL OR INSTITUTION <u>90</u></p>		<p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p>		<p>E. STREET AND NUMBER <u>3610 Howard Park Avenue</u></p>	
<p>5. SEX <u>Male</u></p>	<p>6. RACE <u>White</u></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <u>10-1-1897</u></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Machinist</u></p>		<p>11. BIRTHPLACE (State or foreign country) <u>Maryland</u></p>	
<p>13. FATHER'S NAME <u>Frank Haines</u></p>		<p>14. MOTHER'S MAIDEN NAME <u>Vogle</u></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u></p>		<p>16. SOCIAL SECURITY NO. <u>212-09-8074</u></p>	
<p>17. INFORMANT <u>Kathryn Haines-3610 Howard Park Avenue</u></p>		<p>ADDRESS</p>	
<p>18. <u>492X I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>COR PULMONALE</u></p>		<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 YEARS</u></p>	
<p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>		<p>(B) <u>PULMONARY EMPHYSEMA</u> DUE TO, OR AS A CONSEQUENCE OF: <u>10 YEARS</u></p>	
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p>		<p>(C) _____</p>	
<p>19A. DATE OF OPERATION <u>0</u></p>	<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>	<p>20A. AUTOPSY? (Yes or No)</p>	<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>	<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>	
<p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>	<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>	<p>21F. HOW DID INJURY OCCUR?</p>	
<p>22. I certify that (I) (<del>this hospital</del>) attended the deceased from <u>NOV. 25, 1957</u> to <u>JAN. 22, 1972</u> that (I) (<del>we</del>) last saw the deceased alive on <u>JAN. 18, 1972</u> and that in (my) (<del>our</del>) opinion death occurred on the date and hour and from the causes stated above. (I) (<del>We</del>) (<del>did not</del>) view the body after death.</p>			
<p>23A. SIGNATURE <u>Marvin Goldstein, M.D.</u></p>		<p>23B. DATE SIGNED <u>1/22/72</u></p>	
<p>23C. PHYSICIAN'S NAME (Type) <u>MARVIN GOLDSTEIN, M.D.</u></p>		<p>23D. ADDRESS <u>6001 PARK HEIGHTS AVE. BALTO., MD.</u></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u></p>	<p>24B. DATE <u>1-26-72</u></p>	<p>24C. NAME of CEMETERY or CREMATORY <u>Woodlawn Cemetery</u></p>	<p>24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u></p>
<p>25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1972</u></p>	<p>25B. NAME OF REGISTRAR <u>Robert J. Kelly</u></p>	<p>25C. FUNERAL DIRECTOR <u>Armstrong Funeral Chapel-4600 Liberty Hts</u></p>	

1000 1000 1000

1000 1000

1000 1000 1000

1000 1000 1000

1000 1000

1000 1000

1000 1000

1000 1000 1000 1000 1000

1000 1000

1000

1000 1000

1000

1000 1000

1000 1000 1000

1000 1000

1000 1000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

U-630		72 00777		BALTIMORE CITY HEALTH DEPARTMENT		X		CERTIFICATE OF DEATH		72 00777	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH					
		Anna Leslie Ward				Jan. 21, 1972					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)				A. STATE					
		Md.				B. COUNTY					
FULL NAME OF HOSPITAL OR INSTITUTION		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				C. CITY OR TOWN					
US Public Health Service Hospital		2908 Dunbrin Court				D. INSIDE CITY LIMITS?					
3100 Wyman Parkway						YES <input type="checkbox"/> NO <input type="checkbox"/>					
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		10. UNDER 1 Yr. Months: Days	
Female		Caucasian		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		3/16/88		83		If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Housewife				Scotland		USA					
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
? John Downs				Anna Mc Mickel ?							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS	
No				?		Records- US PHS Hospital, Balto, Md.					
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:						Terminal			
ANTECEDENT CAUSES		(B) Aneurysmal rupture of posterior left ventricle						Unknown			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C) Massive inferior-posterior-septal myocardial infarction						Three days			
II		Severe generalized atherosclerotic cardiovascular disease						Unknown			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from Jan. 11, 1972 to Jan. 21, 1972, that (I) (we) last saw the deceased alive on Jan. 21, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.		23A. SIGNATURE		23B. DATE SIGNED							
Robert L. Wright, MD		1/21/72									
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS									
Robert Wright, SA Surg (R)		US PHS Hospital, Balto, Md.									
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY		24D. LOCATION (City, town, or county) (State)					
burial		24 Jan 72		Arlington National Cemetery		Arlington, Va.					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS					
JAN 25 1972		Robert E. Taylor, MD		Ulrich Funeral Home		Dundalk, Md. 21222					

1700 ST

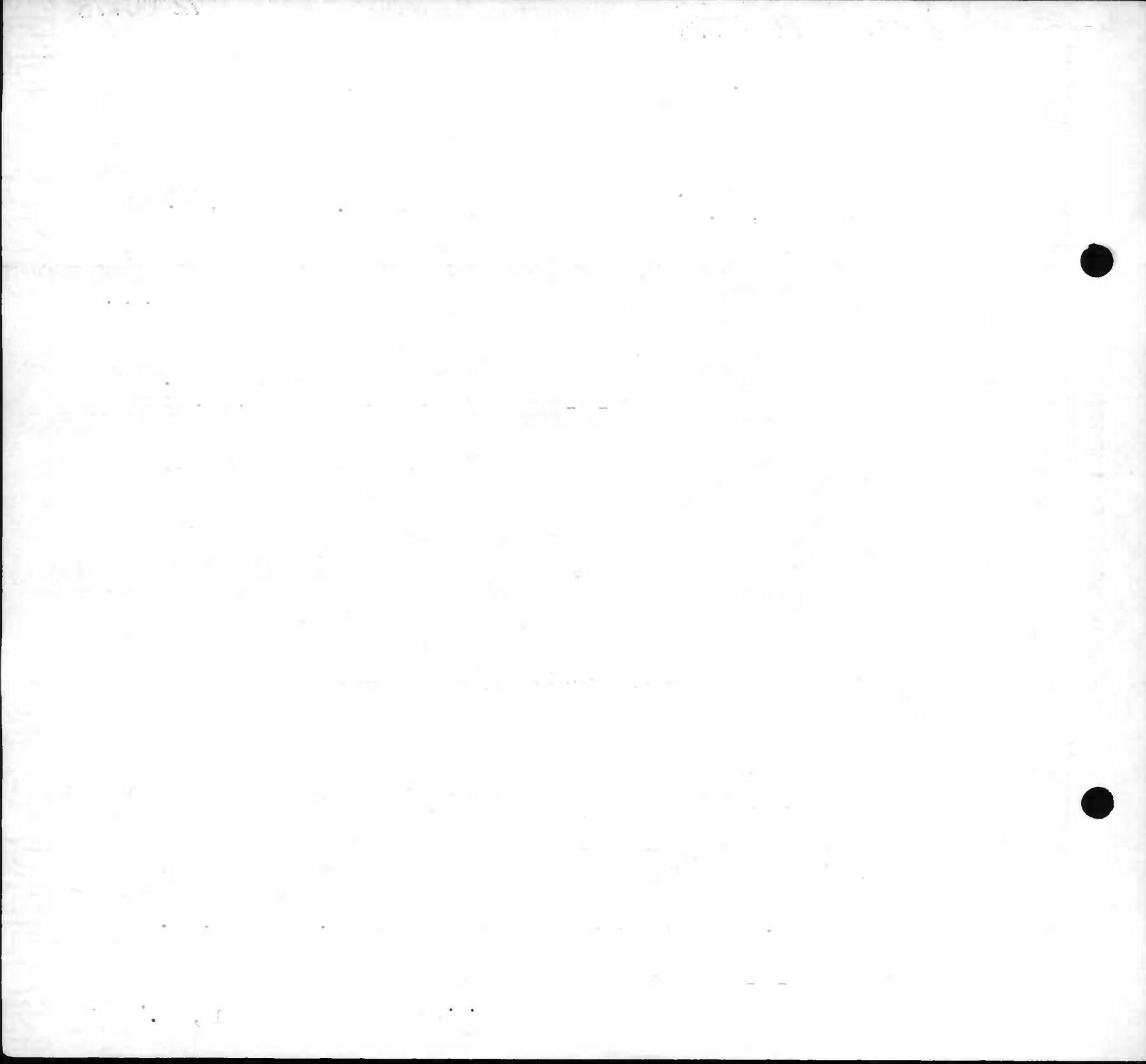
1700 ST





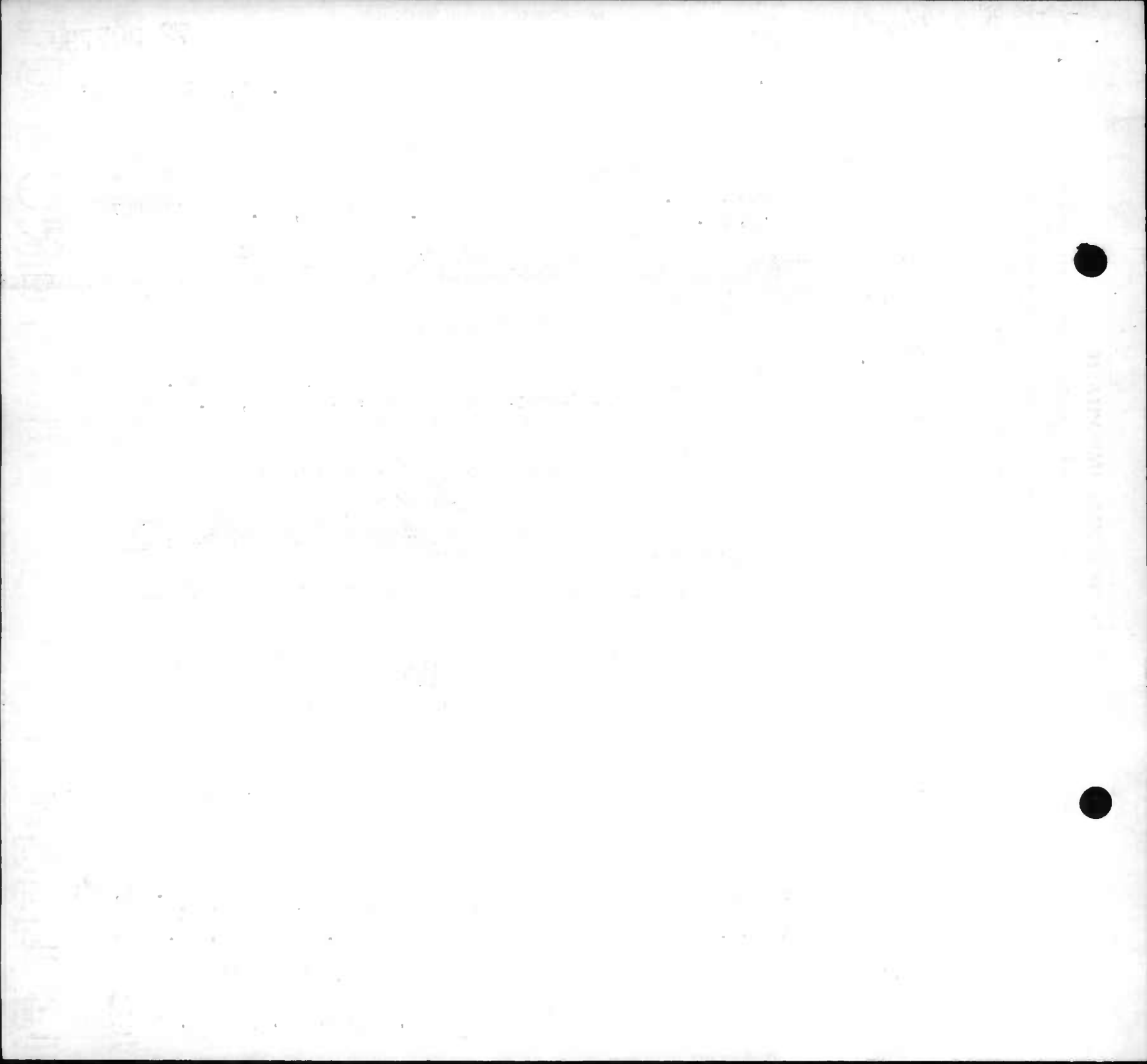
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00778	
BIRTH NO. 72 00778				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) Ruth <sup>B</sup> Andrews			2. DATE AND HOUR OF DEATH 207 pm 11.22.72 M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY Baltimore		
FULL NAME OF HOSPITAL OR INSTITUTION 31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224			C. CITY OR TOWN D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
E. STREET AND NUMBER 868 Jerome Ave. Baltimore, Md. 21265 005					
5. SEX Female	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-10-19	9. AGE (In years last birthday) 52	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY Homemaker	11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Maurice Nowitz			14. MOTHER'S MAIDEN NAME Minnie Hollman		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 218-01-4357	17. INFORMANT ADDRESS 4940 Eastern Ave. BCH Records: Baltimore, Md. 21224		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 560.9 H 183.0 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). metastatic carcinoma			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Cardiorespiratory arrest (B) DUE TO, OR AS A CONSEQUENCE OF: Sepsis (C) DUE TO, OR AS A CONSEQUENCE OF: spontaneous rupture of aortic aneurysm metastatic carcinoma		
19A. DATE OF OPERATION 11.16.72			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED small intestine		
20A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES		
21A. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21B. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from January 14 19 72 to January 22 19 72 that (I) (we) last saw the deceased alive on January 22 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE Wayne B. Leadbetter M.D.			23B. DATE SIGNED 1.22.72		
23C. PHYSICIAN'S NAME (Type) Wayne B. Leadbetter M.D.			23D. ADDRESS Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224		
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-26-1972		24C. NAME of CEMETERY or CREMATORY Belair Memorial Gardens	
24D. LOCATION Belair Harford Maryland		24E. NAME of REGISTRAR E. F. Lassahn			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1972		25B. NAME OF REGISTRAR E. F. Lassahn		25C. FUNERAL DIRECTOR 11750 Belair Rd. Kingsville, Md. 21087	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

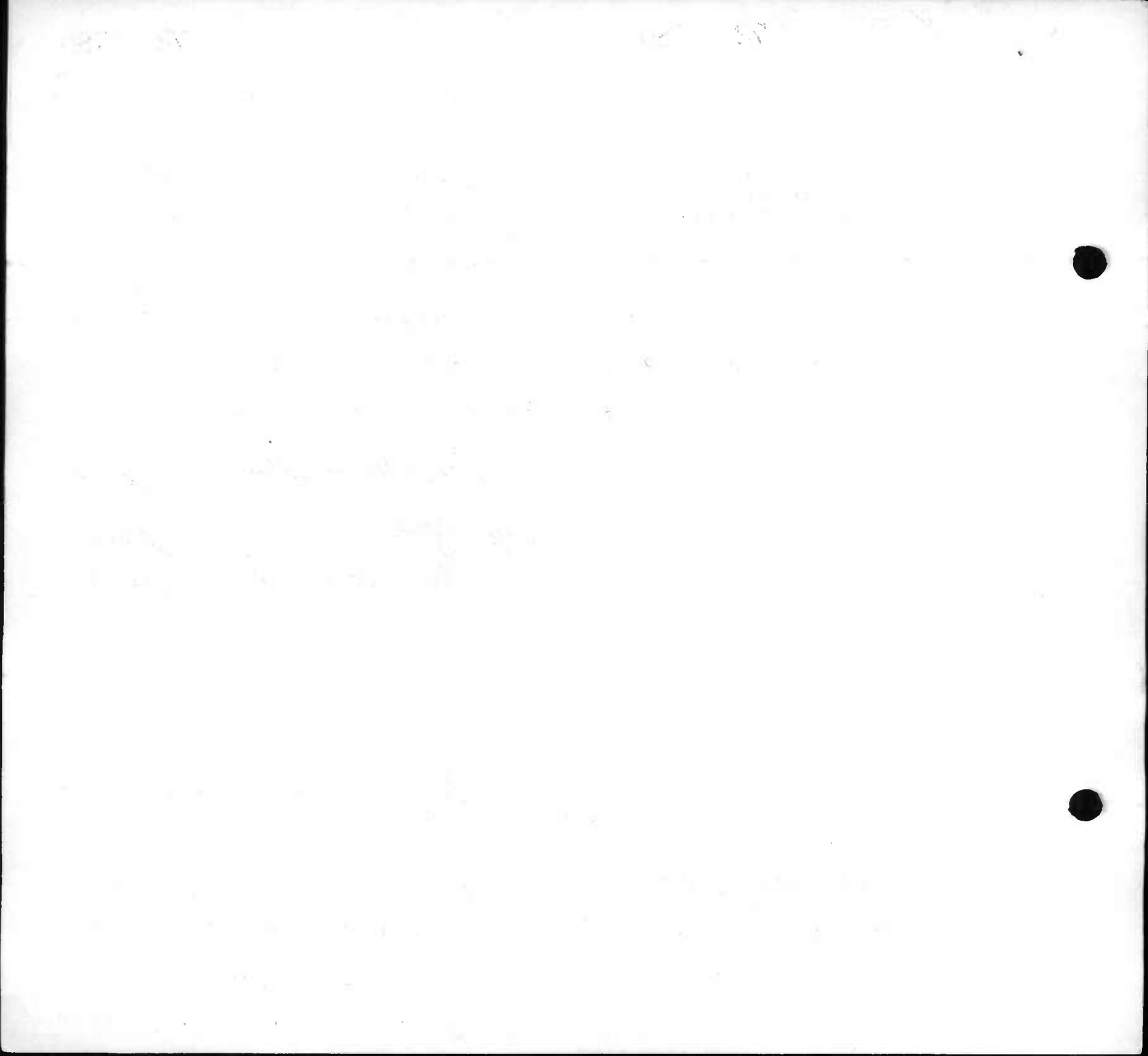
BIRTH NO. <b>M-420</b>		72 00779		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00779</b>	
1. NAME OF DECEASED (Type or Print) <b>John H. Molz</b>				2. DATE AND HOUR OF DEATH <b>Jan. 21, 1972 11:50 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>31 Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2610</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>3223 E. Baltimore, St. 21224 007</b>			
5. SEX <b>Male</b>	6. RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/29/'05</b>	9. AGE (in years last birthday) <b>66</b>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Security Guard (ret)</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Weiskettes</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John H. Molz</b>				14. MOTHER'S MAIDEN NAME <b>Debra White</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>212-09-7141A</b>		17. INFORMANT <b>4940 Eastern Ave. ADDRESS</b> <b>BCH Records: Baltimore, Md. 21224</b>		
18. <b>433.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF <b>Renal &amp; cardiac failure.</b> (B) <b>Cerebral aneurysm &amp; infarct</b> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1-4-72</b> 19 to <b>1-21-72</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1-21-72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Hamid M.D.</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>Jan. 21, 1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>Hamid M.D.</b>				23D. ADDRESS <b>Baltimore City Hospitals 4940 Eastern Ave. Baltimore, Md. 21224</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/24/'72</b>		24C. NAME of CEMETERY or CREMATORY <b>Oak Lawn Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>John A. Morgan, Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>3000 E. Baltimore St</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00780</span>	
<p><b>BIRTH NO.</b> K-655</p> <p><b>1. NAME OF DECEASED</b> (Type or Print) <u>Helen (Karmen) Karmann</u></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <u>1/22/72</u> <u>9<sup>00</sup> P.M.</u></p>			
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>90 Bolton Hill Convalescent Home</u> <u>Lafayette &amp; John Streets</u></p>		<p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>601</u></p> <p>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <u>3012 E. Baltimore St.</u></p>			
<p><b>5. SEX</b> <u>F</u></p>	<p><b>6. RACE</b> <u>W</u></p>	<p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>	<p><b>8. DATE OF BIRTH</b> <u>5/14/16</u></p>		<p><b>9. AGE</b> (In years last birthday) <u>05 yrs</u></p>
<p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laundry Work</u></p>		<p><b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Home Laundry</u></p>		<p><b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u></p>	
<p><b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S. A</u></p>		<p><b>13. FATHER'S NAME</b> <u>Conrad Karmann</u></p>			
<p><b>14. MOTHER'S MAIDEN NAME</b> <u>Blanche Zeiters</u></p>		<p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u></p>			
<p><b>16. SOCIAL SECURITY NO.</b> <u>218-05-2689</u></p>		<p><b>17. INFORMANT</b> <u>Medical Records</u> ADDRESS _____</p>			
<p><b>18. CAUSE OF DEATH</b></p> <p><u>250.9 I</u></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE <u>Diabetes mellitus</u> DUE TO, OR AS A CONSEQUENCE OF: <u>yes</u></p> <p>(B) <u>Brain Tumor</u> DUE TO, OR AS A CONSEQUENCE OF: <u>yes</u></p> <p>(C) <u>arteriosclerosis generalized</u> <u>yes</u></p>					
<p><b>II</b></p> <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>					
<p><b>19A. DATE OF OPERATION</b> <u>0</u></p>		<p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No) _____</p>	
<p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>		<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner)</p>			
<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>		<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>			
<p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)</p>		<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>5/25</u> <b>19</b> <u>70</u> <b>to</b> <u>1/22</u> <b>19</b> <u>71</u></p> <p><b>that (I) (we) last saw the deceased alive on</b> <u>1/2</u> <b>19</b> <u>71</u> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>					
<p><b>23A. SIGNATURE</b> <u>ae madd</u></p>		<p><b>23B. DATE SIGNED</b> <u>1/24/72</u></p>		<p><b>23C. PHYSICIAN'S NAME</b> (Type) <u>ALLAN H. MADD</u></p>	
<p><b>23D. ADDRESS</b> <u>26 Adel St</u></p>		<p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Burial</u></p>			
<p><b>24B. DATE</b> <u>1/26/72</u></p>		<p><b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>Oak Lawn Cemetery</u></p>		<p><b>24D. LOCATION</b> (City, town, or county) (State) <u>Baltimore, Maryland</u></p>	
<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 25 1972</u></p>		<p><b>25B. NAME OF REGISTRAR</b> <u>John E. Taylor, M.D.</u></p>		<p><b>25C. FUNERAL DIRECTOR</b> <u>John A. Morgan, Inc.</u></p>	
<p><b>25D. ADDRESS</b> <u>3000 E. Baltimore St</u></p>		<p><b>25E. ADDRESS</b></p>			



72 00781  
BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 72 00781

BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>Chester Lohr</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 21 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND; WHERE PRONOUNCED DEAD (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 21 72 1:37 p.</b> M.		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1207</b>	
6. SEX <b>male</b>	7. RACE <b>White</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>Mar 1, 1895</b>		10. AGE (In years last birthday) <b>76</b>		E. STREET AND NUMBER <b>261 W. 31st Street</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF <b>U.S.A</b>		13. FATHER'S NAME <b>Berton Lohr</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steam Fitter</b>		14B. KIND OF BUSINESS OR INDUSTRY <b>Balto Bas &amp; Elct.</b>		15. MOTHER'S MAIDEN NAME <b>Alban</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service) <b>Yes W.W.I</b>		17. SOCIAL SECURITY NO. <b>218-07-5451</b>		18. INFORMANT ADDRESS <b>Stanley E. Lohr 261 W 31 St Street</b>	
19. <b>412.4</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		Arteriosclerotic cardiovascular disease			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
		(B) DUE TO, OR AS A CONSEQUENCE OF:			
		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>1/22/72</b> EXAMINER'S NAME (Type)					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/25/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. J. J. M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Honovan Funeral Home 3818 Roland Ave</b>	

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED

RECEIVED



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Paul Wilkins</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 17 72 7:05 P. M.</b>			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>312 S. Collins Avenue</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 17 72 7:05 P. M.</b>			
6. SEX <b>Male</b>				7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>11-24-1921</b>				10. AGE (in years lost birthday) <b>50</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				13. FATHER'S NAME <b>Paul Wilkins</b>			
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				15. MOTHER'S MAIDEN NAME <b>Cornelia Crouch</b>			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>YES</b>				17. SOCIAL SECURITY NO. <b>212-12-5340</b>		18. INFORMANT <b>Mrs F.S. Bortner</b>	
19. <b>571.8</b>				CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE <b>Fatty changes of liver</b> DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.				(B) _____ DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				(C) _____			
20A. DATE OF OPERATION <b>2</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <b>Yes</b>							
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Werner U. Spitz</b> M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-18-72</b>							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
<b>Burial</b>		<b>1-21-72</b>		<b>Good Shepherd</b>		<b>Elliot City Md</b>	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		ADDRESS	
<b>JAN 25 1972</b>		<b>Robert E. Taylor</b>		<b>Slack F.H.</b>		<b>Elliot City Md</b>	

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

10070

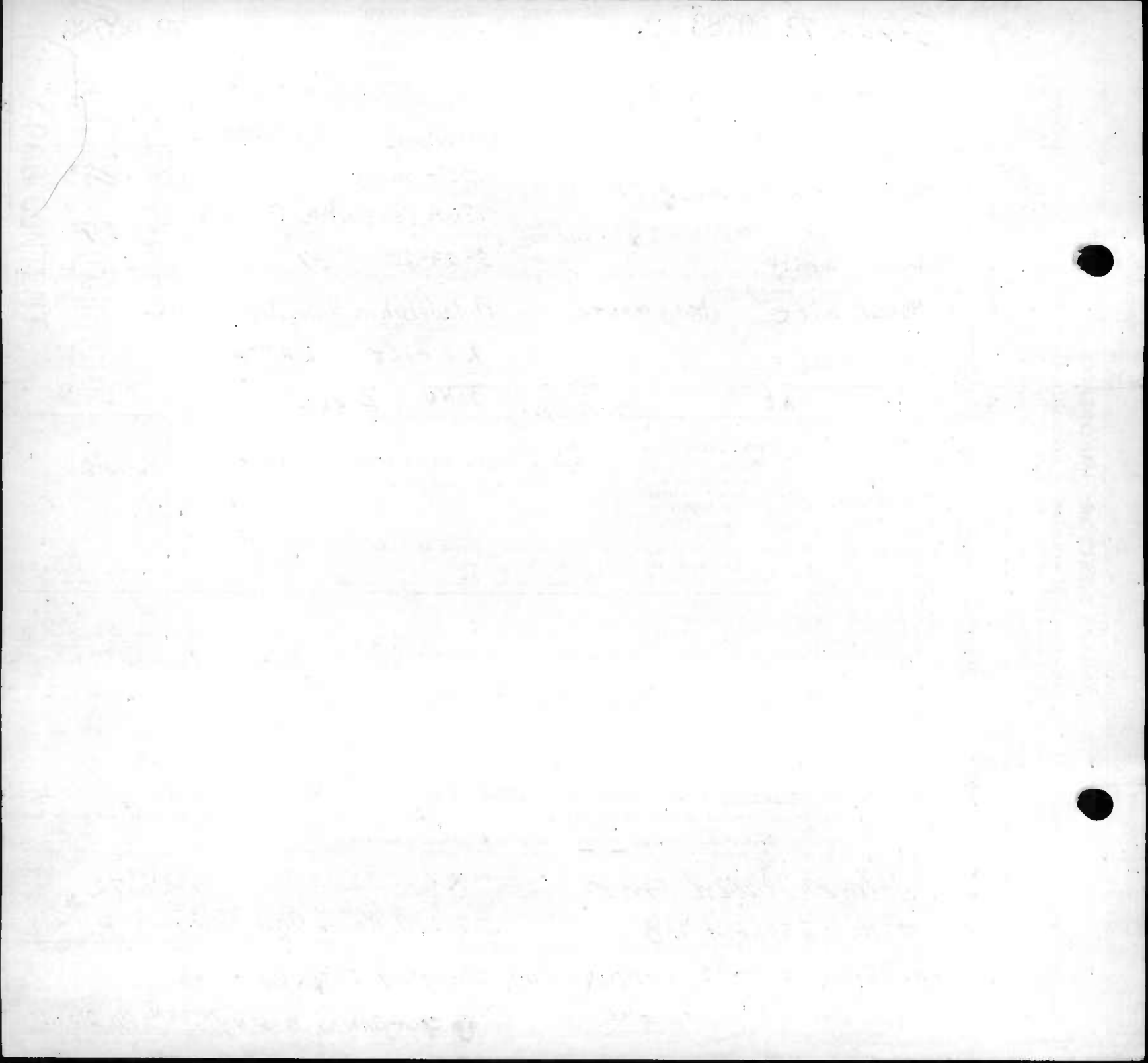
10070

10070

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00783</b>	
<b>G-400 72 00783</b>			
1. NAME OF DECEASED (Type or Print) <b>Lucile L. Gaul</b>		2. DATE AND HOUR OF DEATH <b>18 January 1972 8:40 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>Good Samaritan Hospital</b>		A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>45</b>		E. STREET AND NUMBER <b>139A Versailles Circle</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-23-20</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>		9. AGE (In years last birthday) <b>51</b>	11. BIRTHPLACE (State or foreign country) <b>Philadelphia Pennsylvania</b>
10B. KIND OF BUSINESS OR INDUSTRY <b>Home maker</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Lee C. Leslie</b>		14. MOTHER'S MAIDEN NAME <b>Lucile LATTA</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>191-167811</b>	17. INFORMANT <b>JOHN GAUL</b>
18. <b>183.0 I</b>		ADDRESS	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Carcinoma of Ovary metastases</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____	
<b>II</b>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). _____			
19A. DATE OF OPERATION <b>1</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Dec 30 1971</b> to <b>18 Jan 1972</b> , that (I) (we) last saw the deceased alive on <b>18 Jan 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>John D. Talbert, MD</b>		Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>	23B. DATE SIGNED <b>18 Jan 72</b>
23C. PHYSICIAN'S NAME (Type) <b>John D. Talbert, MD</b>		23D. ADDRESS <b>5601 Loch Raven Blvd. Baltimore MD 21239</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>	24B. DATE <b>1-19-72</b>	24C. NAME OF CEMETERY or CREMATORY <b>LONDON PARK CREMATORY</b>	24D. LOCATION (City, town, or county) (State) <b>CATON VILLE, MD.</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>	25B. NAME OF REGISTRAR <b>John D. Talbert, MD</b>	25C. FUNERAL DIRECTOR <b>Mr. GORDON BROOKS, TOWSON, MD. 21204</b>	ADDRESS



# FUNERAL DIRECTOR: IMPORTANT

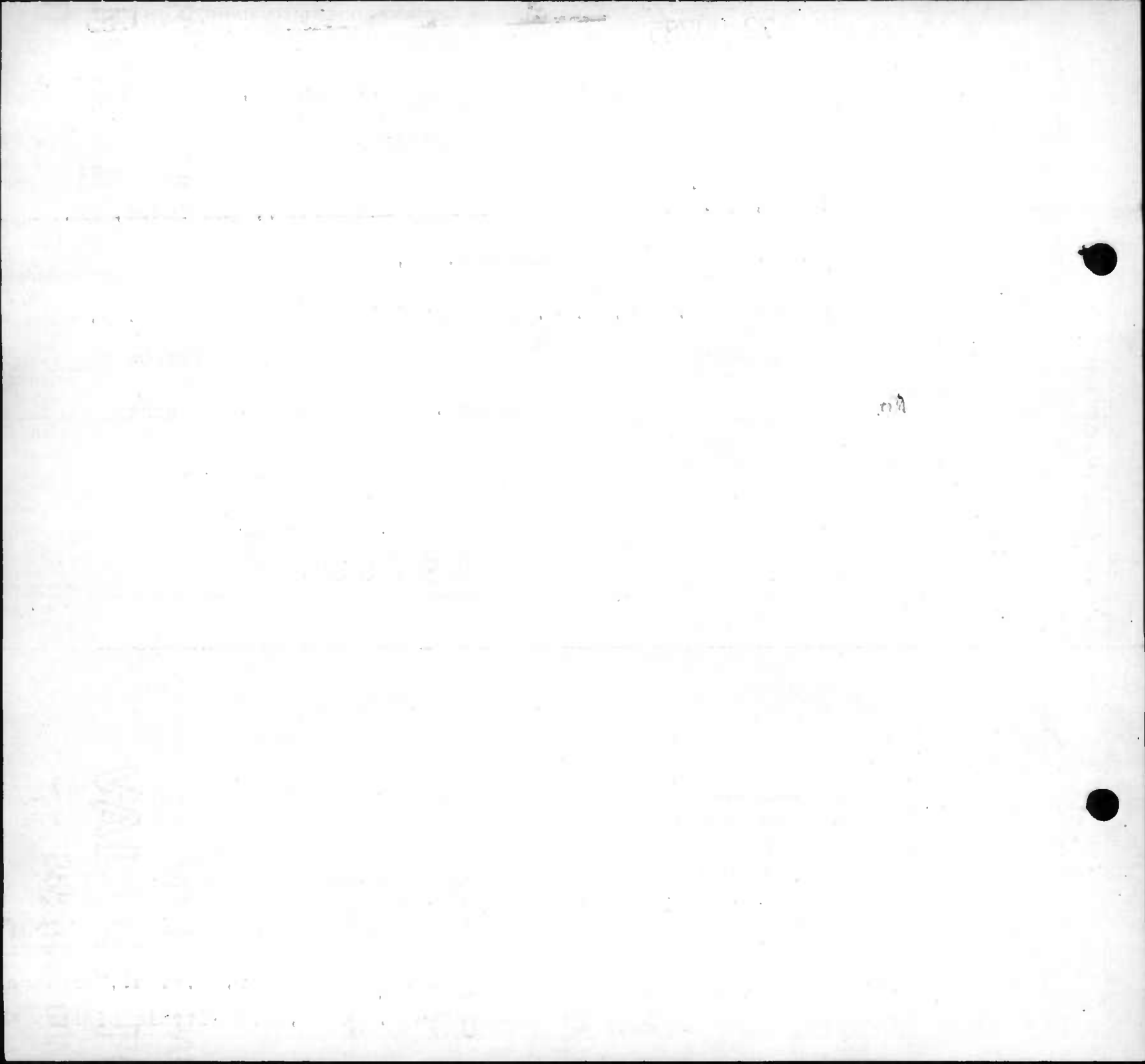
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <b>72 00784</b>	
BIRTH NO. <b>S-200 72 00784</b>					
1. NAME OF DECEASED (Type or Print) <b>DORIS L. SAUSE (HOLLIDAY)</b>		2. DATE AND HOUR OF DEATH <b>1/22/72 10:15 PM</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>21214</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>5619 PIONEER DRIVE</b>		C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <b>5619 PIONEER DRIVE</b>					
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/15/1921</b>	9. AGE (In years last birthday) <b>50</b>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>HOLLIDAY</b>		14. MOTHER'S MAIDEN NAME <b>MILDRED AMOS</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>219-18-9576</b>		17. INFORMANT <b>BERNARD J. SAUSE, SR.</b>	
18. <b>154.1 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic carcinoma carcinoma of rectum</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Metastatic carcinoma carcinoma of rectum</b>			
(B) DUE TO, OR AS A CONSEQUENCE OF:		(C) DUE TO, OR AS A CONSEQUENCE OF:			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Incontinence &amp; dehydration</b>					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1969</b> to <b>1/23</b> <b>1972</b> , that (I) (we) last saw the deceased alive on <b>1/22</b> <b>1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Robert E. Martin</b>				23B. DATE SIGNED <b>1/23/1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>ROBT. E. MARTIN, MD</b>				23D. ADDRESS <b>3201 No. Charles St.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>		24B. DATE <b>1/24/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>(BRADLEY) LOUDON</b>	
24D. LOCATION (City, town, or county) (State) <b>BALTIMORE, MD.</b>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Robt E. Martin</b>		25C. FUNERAL DIRECTOR <b>Robt E. Martin</b>	

1. *Journal of the American Medical Association*, 1990; 263: 1027-1031.

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

R-360		72 00785		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00785	
BIRTH NO.				2. DATE AND HOUR OF DEATH			
1. NAME OF DECEASED (Type or Print)				January 18, 1972 1:55 P.M.			
CARL EUGENE RADER							
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				A. STATE B. COUNTY			
1523 Locust St. Baltimore, Md. 21226				Maryland			
				C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER			
				1523 Locust St., Baltimore, Md.			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months	11. Under 24 Hrs. Days	12. Under 24 Hrs. Hours
Male	Caucasian	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Apr. 30, 1905	66			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Railroad Carmen				B. & O. R. R.		Virginia	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
John Rader				Furrow			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No				233 20 0902		Mrs. Carl Rader (Mona) same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				CAUSE OF DEATH			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSES				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				Pulmonary Emphysema			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				Chronic Bronchitis			
				(C) ASCVD.			
II							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from May 16 1969 to January 18 1972, that (I) (we) last saw the deceased alive on 11 - 1 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
E. H. Weiss				1-19-72			
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
E. H. Weiss				615 Hamonds Lane - Balto. - Md. 21225			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1/21/72		Glen Haven Memorial pk		Glen Burnie, A.A.Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS			
JAN 25 1972		George J. Gonce		4001 Ritchie Highway			

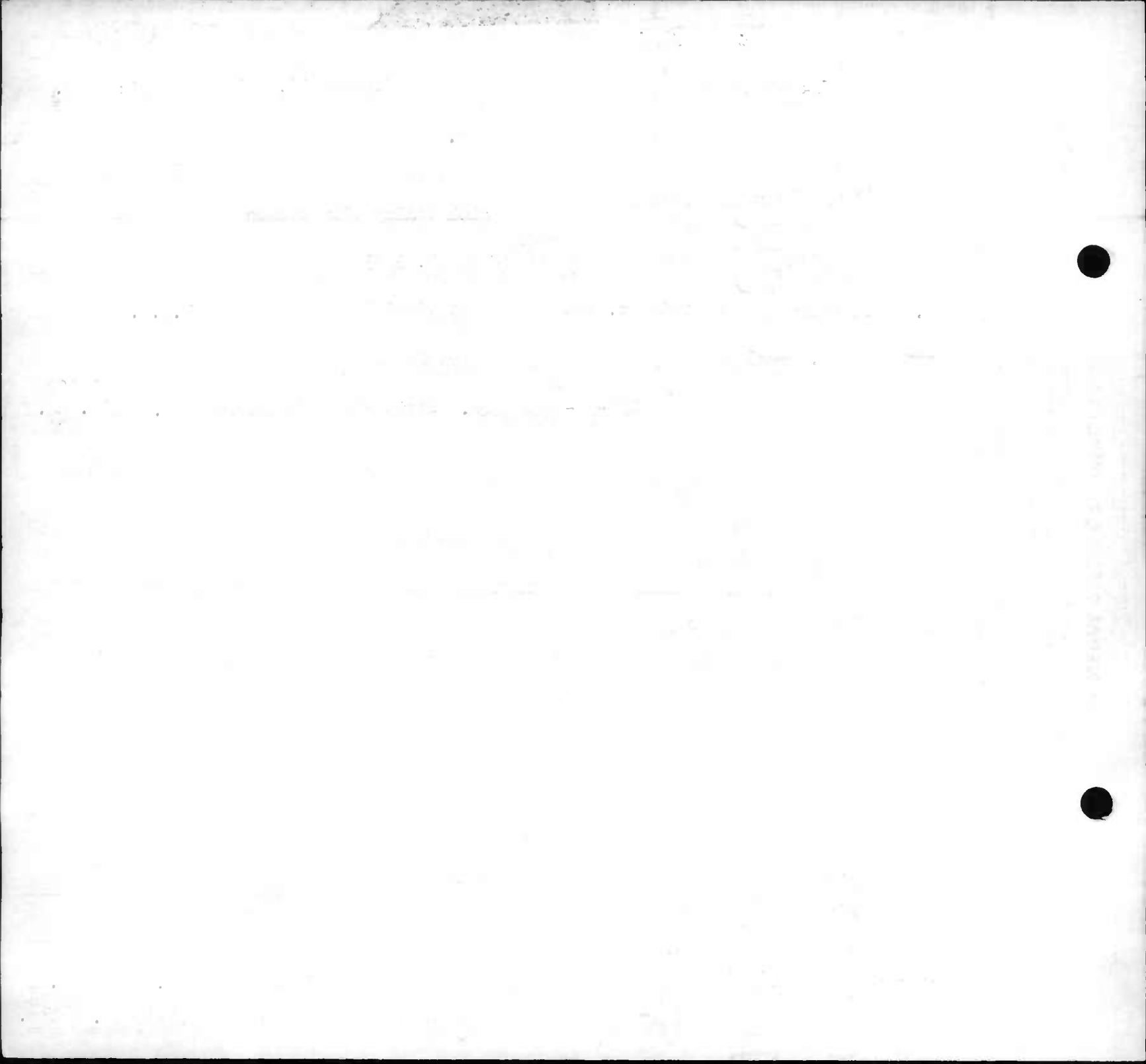




# FUNERAL DIRECTOR: IMPORTANT

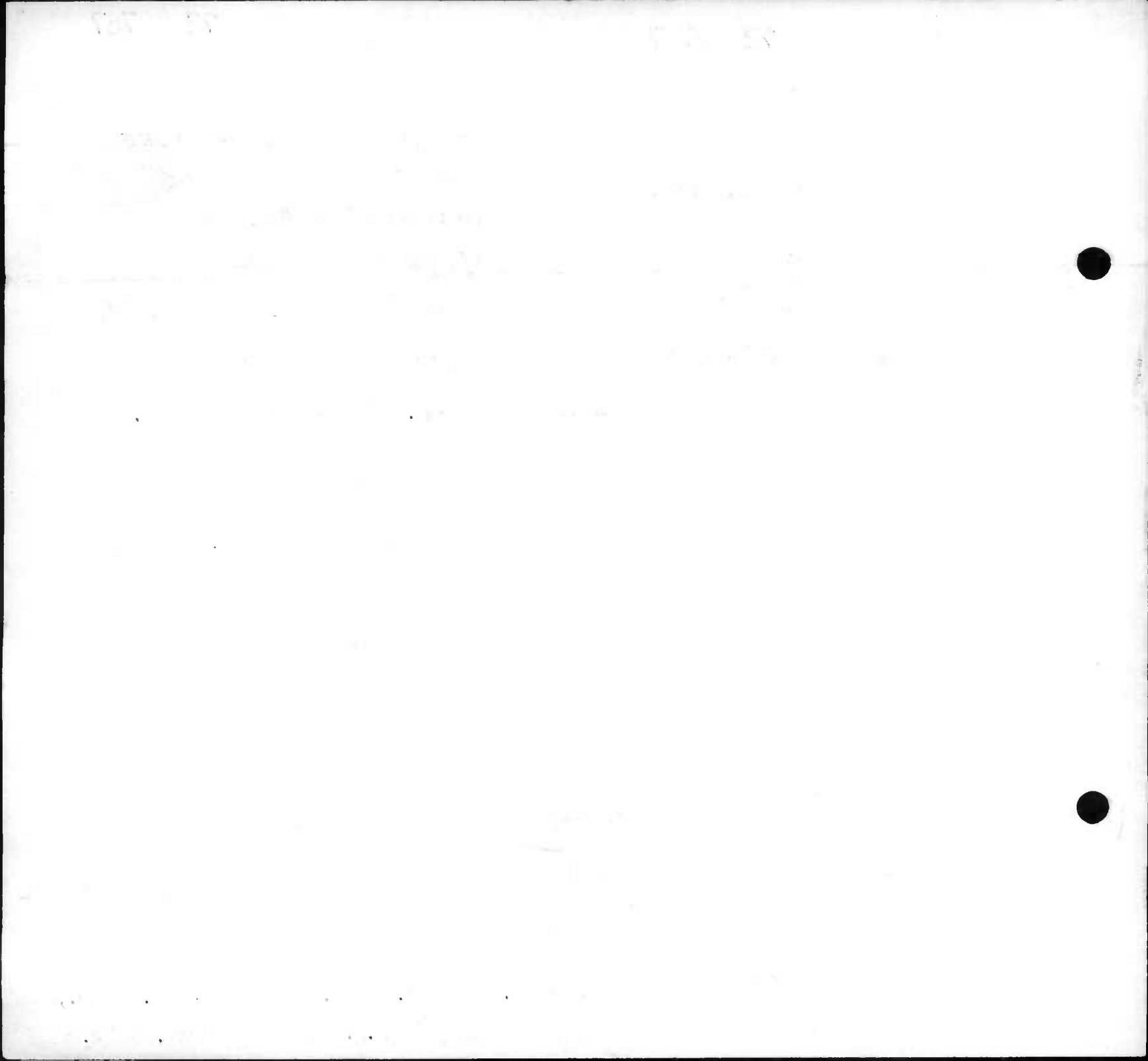
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 00786</b>	
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>Alta Elizabeth Samples</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>January 20, 1972</u>   <u>12:00 P. M.</u>			
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>4201 Valley View Avenue</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2632</u> <b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>4201 Valley View Avenue</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>June 11, 1903</u>	<b>9. AGE</b> (In years last birthday) <u>68</u>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Ret. Timekeeper</u>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Ret. Timekeeper</u>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <u>Martin Co.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>West Virginia</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		<b>13. FATHER'S NAME</b> <u>Marmaduke A. Samples</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Dora Bailey</u>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b> <u>234-35-0446</u>		<b>17. INFORMANT</b> <u>Mrs. Hattie Wilson</u> <b>ADDRESS</b> <u>21220</u> <u>23 Compass Rd. Balto. Md.</u>			
<b>18. CAUSE OF DEATH</b>					
<b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>410.9 / 250.9</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			<b>(A) IMMEDIATE CAUSE</b> <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) ASCEND</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C)</b>		
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <u>DIABETES MELLITUS</u>			<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <u>SUDDEN</u> <u>10+ YRS</u> <u>2 YRS</u>		
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>		<b>20A. AUTOPSY?</b> (Yes or No)	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>1/11</u> <b>19</b> <u>46</u> <b>to</b> <u>1/22</u> <b>19</b> <u>72</u> <b>that (I) (we) last saw the deceased alive on</b> <u>1/14</u> <b>19</b> <u>72</u> <b>and that in (my) (our) opinion death occurred on the date</b> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <u>P. Berger MD</u> <b>DEGREE</b>				<b>23B. DATE SIGNED</b> <u>1/22/72</u>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <u>L. P. BERGER MD</u> <b>DEGREE</b>				<b>23D. ADDRESS</b> <u>8100 HARFORD RD</u>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <u>Entombment</u>		<b>24B. DATE</b> <u>1/24/72</u>		<b>24C. NAME of CEMETERY or CREMATORY</b> <u>Moreland Mausoleum</u>	
<b>24D. LOCATION</b> (City, town, or county) <u>Parkville</u>		<b>24E. STATE</b> <u>Balto.</u>		<b>24F. ADDRESS</b> <u>Md.</u>	
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 25 1972</u>		<b>25B. NAME OF REGISTRAR</b> <u>R. E. J. G. 820</u>		<b>25C. FUNERAL DIRECTOR</b> <u>Passing Funeral Home</u>	
<b>25D. ADDRESS</b> <u>7401 Belair Rd. Balto.</u>		<b>25E. ADDRESS</b> <u>21236</u>			



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

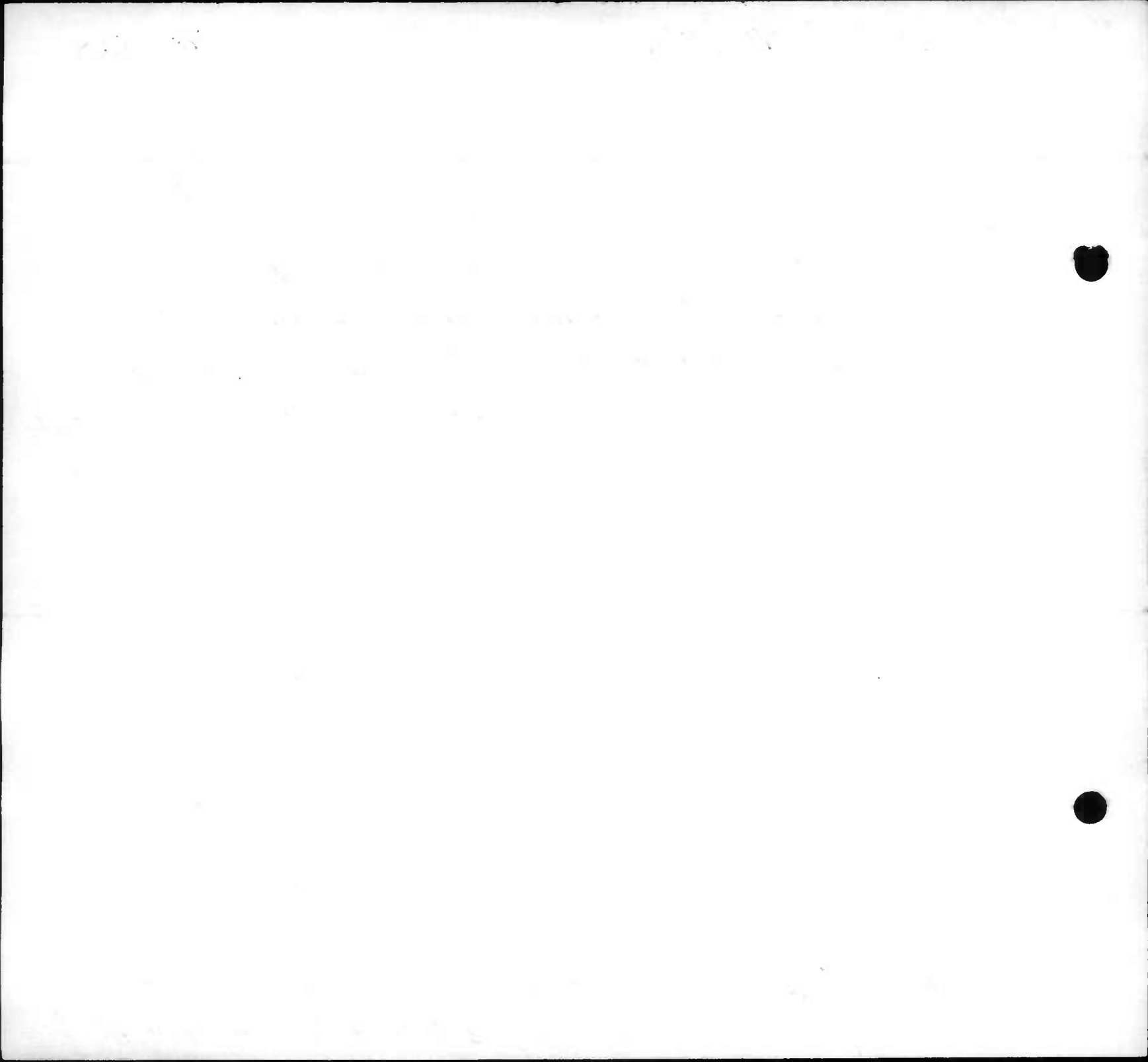
B-630		72 00787		BALTIMORE CITY HEALTH DEPARTMENT		72 00787	
BIRTH NO.				REG. NO.			
1. NAME OF DECEASED (Type or Print) <u>NANCY E. BRADY</u>				2. DATE AND HOUR OF DEATH <u>1/19/72</u> <u>4:53 P.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>BON SECOURS HOSPITAL</u> <u>34</u>				A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u> <u>2534</u>			
				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <u>3800 LEADENHALL ST.</u>			
5. SEX <u>F</u>	6. RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/5/45</u>	9. AGE (In years lost birthday) <u>26</u>	10. Under 1 Yr. Months Days	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>HARRY LYBERGERY</u>				14. MOTHER'S MAIDEN NAME <u>EMMA L. BURKE</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>218-42-0424</u>		17. INFORMANT <u>Husband</u> ADDRESS <u>James W. Brady 3800 Leadenhall St. 21225</u>	
18. <u>637.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pneumonia, RLL+LL</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Pre-eclampsia, severe</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Diabetes Mellitus</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>days</u> <u>days</u> <u>years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				<u>Obesity, marked</u>			
19A. DATE OF OPERATION <u>January 19, 72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Pre-eclampsia - Caesarian Section</u>		20A. AUTOPSY? (Yes or No) <u>Yes</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <u>HT</u> (this hospital) attended the deceased from <u>January 16</u> 1972 to <u>January 19</u> 1972 that <u>HT</u> (we) last saw the deceased alive on <u>January 19</u> 1972 and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Thien Thitivanana</u> M.D.				23B. DATE SIGNED <u>January 19, 1972</u>			
23C. PHYSICIAN'S NAME (Type) <u>THIEN THITIVANANA</u>				23D. ADDRESS <u>BON SECOURS HOSPITAL</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/24/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>Meadowridge Mem. Park Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Wash. Blvd &amp; Dorsey Rd. Balto., MD</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1972</u>		25B. NAME OF REGISTRAR <u>U.S. DE. HEALTH</u>		25C. FUNERAL DIRECTOR <u>10 CALLOF.B.</u>		ADDRESS <u>237 Patapsco Ave. Balto. 21225</u>	



**FUNERAL DIRECTOR: IMPORTANT**

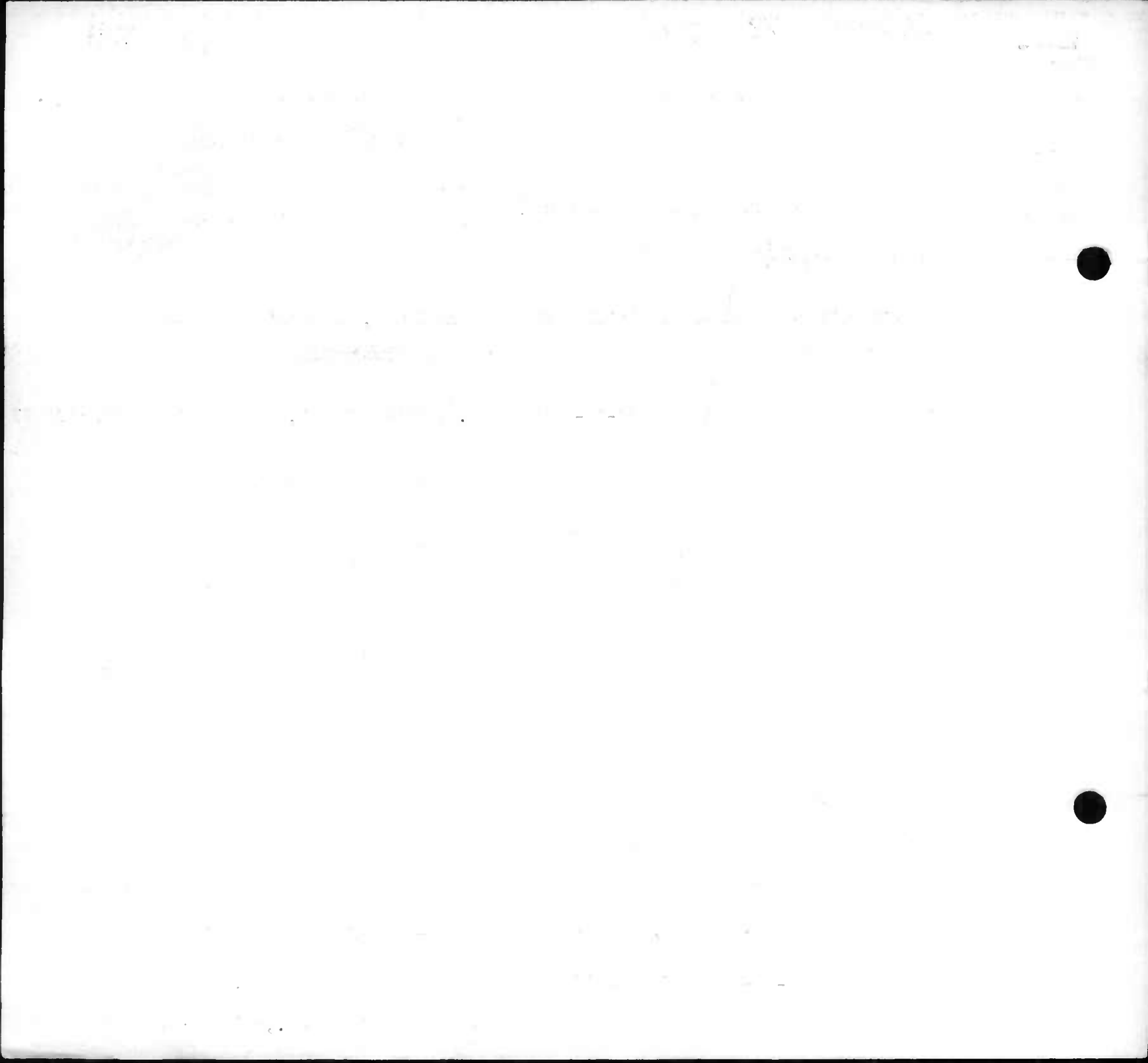
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-620 72 00788		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00788
1. NAME OF DECEASED (Type or Print) <b>PATRICIA BURROWS</b>		2. DATE AND HOUR OF DEATH <b>1-20-72 12 35 P. M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>University of Md. Hospital 38</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>ARUNDEL</b> C. CITY OR TOWN <b>ANNAPOLIS</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>PRESIDENT ST. 910</b>		
5. SEX <b>FEMALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>19 Sep 1952</b> 9. AGE (in years last birthday) <b>19</b> If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>
12. CITIZEN OF WHAT COUNTRY <b>USA</b>		13. FATHER'S NAME <b>DAVID E. White SR</b>		
14. MOTHER'S MAIDEN NAME <b>Evelyn Drury</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		
16. SOCIAL SECURITY NO.		17. INFORMANT <b>LAURENCE BURROWS, SAME AS 4</b>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>6.32.41</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Hypertensive shock, renal failure 4 hrs.</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>Hypofibrinogenemia Anaphylactoid</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19. DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>NO</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <b>1-20-1972</b> to <b>1-20-1972</b> that (I) (we) last saw the deceased alive on <b>1-20-1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <b>S. L. Loomis, M.D.</b>		23B. DATE SIGNED <b>1-20-72</b>		23C. PHYSICIAN'S NAME (Type) <b>BAMKONG CERDROON</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/24/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Glen Haven</b>
24D. LOCATION (City, town, or county) (State) <b>Glen Burnie AA Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		
25B. NAME OF REGISTRAR <b>John E. G. 220</b>		25C. FUNERAL DIRECTOR <b>Funeral Home, Burnie</b>		



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00789	
BIRTH NO. <u>H-322</u> <u>72 00789</u>					
1. NAME OF DECEASED (Type or Print) <u>HODGES, Leo Joseph</u>		2. DATE AND HOUR OF DEATH <u>1/19/72</u> <u>11:20 p.m.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <u>33 The Johns Hopkins Hospital</u>		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <u>3708 Milford Mill Road</u>			
5. SEX <u>Male</u>	6. RACE <u>WHITE</u> <del>CAUCAS</del>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/15/14</u>	9. AGE (in years last birthday) <u>57</u>	10. Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SECURITY DIVISION ANDREWS AIR FORCE BASE</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Joseph Hodges</u>		14. MOTHER'S MAIDEN NAME <u>Mary Goldberry</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>216-10-8247</u>		17. INFORMANT <u>MRS. ESTELLE HODGES, 3708 MILFORD MILL ROAD #7</u>	
18. <u>157.9</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Respiratory/Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>Hepatic Coma; Diffuse GI bleeding</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>Advanced Carcinoma of pancreas</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> <u>3 mo.</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>Yes</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>1/15</u> <u>72</u> to <u>1/19</u> <u>72</u> that (2) (we) last saw the deceased alive on <u>1/19</u> <u>72</u> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Jean F. Hobbs M.D.</u>		23B. DATE SIGNED <u>1/19/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Jean F. Hobbs, MD.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>		24B. DATE <u>1-21-72</u>		24C. NAME of CEMETERY or CREMATORY <u>NEW HAR SINAI</u>	
24D. LOCATION (City, town, or county) (State) <u>REISTERSTOWN, MARYLAND</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Fisher</u>		25C. FUNERAL DIRECTOR <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>			





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO.		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
Glassgold, Solomon S.		Jan. 18 1972		2:50 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)		A. STATE		B. COUNTY	
Sinai Hospital of Baltimore Inc.		Maryland		Baltimore	
422		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		Baltimore		YES <input type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER		3204 CLARKS LANE		#21215	
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
MALE	XXXXWHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	10-15-90	81	11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
VICE PRESIDENT		MASONARY CONST. CO.		RUSSIA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
SOLOMON S. GLASSGOLD		CIPPORAH ?		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
NO		199-01-0124		ADDRESS	
		MRS. ANNA GLASSGOLD, 3204 CLARKS LANE		#21215	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		(A) IMMEDIATE CAUSE		5 minutes	
(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)		DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES		(B) C.H.F. - 500515		5 days	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		DUE TO, OR AS A CONSEQUENCE OF:			
(C)					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
0				No	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(APPROX.)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-12 19 72 to 1-18 19 72 that (I) (we) last saw the deceased alive on 1-18 19 72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Jack Pollack M.D.		Jan. 18, 1972			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
JACK POLLACK		SINAI HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		1-21-72		CHIZUK AMUNO (ARLINGTON)	
24D. LOCATION (City, town, or county)		24E. STATE			
BALTIMORE, MARYLAND					
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 25 1972		Robert E. Taylor, M.D.		SOL LEVINSON & BROS.	
				ADDRESS	
				6010 REISTERSTOWN ROAD	

100-87

100-87

100-87

100-87

100-87

100-87

100-87

100-87

100-87

100-87

100-87

100-87

100-87

100-87

100-87

100-87

100-87

100-87

100-87

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00791		72 00791	
BIRTH NO. <span style="font-size: 1.5em;">H-635</span>				72 00791		REG. NO. <span style="font-size: 1.5em;">X</span>	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Edna Harding</span>				2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">1-14-72</span> <span style="float: right;"><span style="font-size: 1.2em;">6:40</span> <span style="float: right;">P</span></span>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.5em;">40</span> <span style="font-size: 1.2em;">St. Agnes Hospital</span> <span style="font-size: 1.2em;">Caton &amp; Wilkens Avenue</span> <span style="font-size: 1.2em;">Baltimore, Maryland</span>				C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <span style="font-size: 1.2em;">F</span>				6. RACE <span style="font-size: 1.2em;">N</span>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <span style="font-size: 1.2em;">5-10-23</span>				9. AGE (In years last birthday) <span style="font-size: 1.2em;">48</span>		10. Under 1 Yr. Months: Days: If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>	
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A.</span>				13. FATHER'S NAME <span style="font-size: 1.2em;">Stanley Harding</span>			
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Beatrice Clark</span>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <span style="font-size: 1.5em;">410.9 192.50.9</span> (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <span style="font-size: 1.2em;">Diabetes mell - Pulm. edema</span>				CAUSE OF DEATH <span style="font-size: 1.2em;">Acute thrombosis right coronary artery</span> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">antiseptol M.I. recent</span> (B) DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.2em;">A S C V D.</span> (C)  APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">24 hrs</span> <span style="font-size: 1.2em;">6 weeks</span> <span style="font-size: 1.2em;">6 yrs</span>			
19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No) <span style="font-size: 1.2em;">YES</span>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">January 14,</span> <span style="font-size: 1.2em;">1972</span> to <span style="font-size: 1.2em;">January 14,</span> <span style="font-size: 1.2em;">1972</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">19</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <span style="font-size: 1.5em;">Jose Apter M.D.</span>				23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Jose Apter, M.D.</span>	
23D. ADDRESS <span style="font-size: 1.2em;">St. Agnes Hospital</span>				23E. FUNERAL DIRECTOR <span style="font-size: 1.2em;">Bolt K. Snowden</span>			
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>				24B. DATE <span style="font-size: 1.2em;">1/19/72</span>		24C. NAME of CEMETERY or CREMATORY <span style="font-size: 1.2em;">First Baptist Cemetery</span>	
24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Guilford, Howard, Maryland</span>				24E. ADDRESS <span style="font-size: 1.2em;">246 N. Wash. St. Rockville, Md. 20850</span>			
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 25 1972</span>				25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. ...</span>			

Edward L. H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>G-650</b></span> <span><b>72 00792</b></span> </div>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		<b>REG. NO. 72 00792</b>	
<b>BIRTH NO.</b> [REDACTED]		<b>1. NAME OF DECEASED</b> (Type or Print) <b>ROBERT GREEN</b>		<b>2. DATE AND HOUR OF DEATH</b> <b>1/23/72 4:30 P.M.</b>	
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>CHURCH HOME + HOSP.</b>		<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2798</b>		<b>5. CITY OR TOWN</b> <b>BALTIMORE</b>	
<b>6. FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <b>CHURCH HOME + HOSP.</b>		<b>7. D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		<b>8. E. STREET AND NUMBER</b> <b>4730 WILHELM AVE</b>	
<b>9. SEX</b> <b>M.</b>	<b>10. RACE</b> <b>negro</b>	<b>11. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>12. DATE OF BIRTH</b> <b>1/2/25</b>	<b>13. AGE (In years last birthday)</b> <b>47</b>	<b>14. If Under 1 Yr. Months Days</b> <b>47</b>
<b>15. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>const. worker</b>		<b>16. KIND OF BUSINESS OR INDUSTRY</b> <b>Maintenance</b>		<b>17. BIRTHPLACE</b> (State or foreign country) <b>MD</b>	
<b>18. FATHER'S NAME</b> <b>Robert Green</b>		<b>19. MOTHER'S MAIDEN NAME</b> <b>Pessie Bolton</b>		<b>20. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b>	
<b>21. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		<b>22. SOCIAL SECURITY NO.</b> <b>216-14-8625</b>		<b>23. INFORMANT</b> <b>pt.'s doctor in hosp.</b>	
<b>24. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>25. ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>pt. had cardiac resuscitation</b>		<b>26. IMMEDIATE CAUSE</b> <b>encephalopathy</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(B) hypertension</b> DUE TO, OR AS A CONSEQUENCE OF: <b>(C) obesity</b>		<b>27. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <b>days</b> <b>years</b> <b>years</b>	
<b>28. DATE OF OPERATION</b> <b>1/23/72</b>		<b>29. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>pt. had cardiac resuscitation</b>		<b>30. AUTOPSY?</b> (Yes or No) <b>No</b>	
<b>31. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (naffly medical examined) <input type="checkbox"/>		<b>32. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>CHH</b>		<b>33. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <b>CHH</b>	
<b>34. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) <b>1/23/72</b>		<b>35. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>36. HOW DID INJURY OCCUR?</b> <b>CHH</b>	
<b>37. I certify that (I) (this hospital) attended the deceased from 1/21/72 to 1/23/72 that (I) (we) last saw the deceased alive on 1/23/72 and that (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>38. SIGNATURE</b> <b>Dietrich V. Feldmann</b>		<b>39. DATE SIGNED</b> <b>1/23/72</b>		<b>40. ATTENDING PHYSICIAN</b> <input type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYSICIAN</b> <input checked="" type="checkbox"/>	
<b>41. PHYSICIAN'S NAME</b> (Type) <b>DIETRICH V. FELDMANN</b>		<b>42. ADDRESS</b> <b>CHH</b>		<b>43. DATE REC'D BY HEALTH DEPT.</b> <b>1/27/72</b>	
<b>44. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>45. DATE</b> <b>1/27/72</b>		<b>46. NAME OF CEMETERY OR CREMATORY</b> <b>Wm. A. Auburn Cem. Balto. City</b>	
<b>47. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 25 1972</b>		<b>48. NAME OF REGISTRAR</b> <b>Wm. A. Auburn</b>		<b>49. FUNERAL DIRECTOR</b> <b>Wm. A. Auburn</b>	
<b>50. ADDRESS</b> <b>Wm. A. Auburn</b>		<b>51. ADDRESS</b> <b>Wm. A. Auburn</b>		<b>52. ADDRESS</b> <b>Wm. A. Auburn</b>	

SECRET

~~SECRET~~



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-630 72 00793		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		Registered No. 72 00793	
BIRTH NO. <b>1</b>					
M.E. CASE NO.					
1. NAME OF DECEASED (Type or Print) <b>MAMIE A. Byrd</b>			2. DATE AND HOUR OF DEATH <b>1-22-72 11:15 P.M.</b>		
3. PLACE OF DEATH IN BALTIMORE, MARYLAND			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>508</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>1616 E. Biddle St.</b>			C. CITY OR TOWN (If outside city limits, write RURAL and give township) <b>BALTO.</b>		
			D. STREET ADDRESS (If rural, give location) <b>1616 E. Biddle St.</b>		
5. SEX <b>F.</b>	6. RACE <b>C. N</b>	7. MARRIED, NEVER MARRIED WIDOWED, DIVORCED (specify) <b>Widow</b>	8. DATE OF BIRTH <b>11/1/96</b>	9. AGE (In years last birthday) <b>76</b>	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>UTAH ALA.</b>	
13. FATHER'S NAME <b>LEVI HUNTINGTON</b>			14. MOTHER'S MAIDEN NAME <b>LUCY SWAIN</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>IMOGENE B. Douglas 1603 E. Biddle St</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>412141250.9</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) <b>UREMIA</b> DUE TO		INTERVAL BETWEEN ONSET AND DEATH <b>5 years</b>
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) <b>Arteriosclerosis</b> DUE TO		<b>unknown</b>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT. <b>Arteriosclerotic Heart Disease</b> <b>Diabetes Mellitus</b>					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>September 19 1966</b> to <b>January 23 1972</b> , that (I) (we) last saw the deceased alive on <b>January 3 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Richard D Hahn</b>			M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <b>January 24-1972</b>
23C. PHYSICIAN'S NAME (Type) <b>RICHARD D HAHN</b>			23D. ADDRESS <b>2106 SOUTH ROAD 21209 Balto Md</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/26/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Arbutus mem. PK</b>	
				24D. LOCATION (City, town, or county) (State) <b>ARbutus MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Baker</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Joseph J. Locks 1304 N. Central Ave</b>	

1913

W. E. C. 2112  
1112 25  
1112 25  
1112 25  
1112 25

W. E. C. 2112  
1112 25  
1112 25  
1112 25  
1112 25

W. E. C. 2112

W. E. C. 2112

W. E. C. 2112



B-650

72 00794

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00794

BIRTH NO.

REG. NO.

1. NAME OF DECEASED (Type or Print) <b>ELLA BROWN</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 2503 Edmondson Ave.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 23 1972 11:55p M.</b>	
6. SEX <b>female</b>		7. RACE <b>negro</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>Oct 12-1909</b>		10. AGE (In years last birthday) <b>62</b>	
11. BIRTHPLACE (State or foreign country) <b>AMOLIA CO VA</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>JOSEPH BROWN</b>		14. MOTHER'S MAIDEN NAME <b>JULIA MANN</b>	
15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		16. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		18. SOCIAL SECURITY NO. <b>220-24-9074</b>	
19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.) <b>Hypertensive &amp; arteriosclerotic cardiovascular disease</b>		20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
21. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		22. DUE TO, OR AS A CONSEQUENCE OF:	
23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		24. DUE TO, OR AS A CONSEQUENCE OF:	
25. DATE OF OPERATION <b>2</b>		26. CONDITION FOR WHICH OPERATION WAS PERFORMED	
27. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
29. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) (m.)		30. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
31. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		32. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>1-24-72</b>			
24A. BURIAL CREMATION REMOVAL (Specify) <b>Burned</b>		24B. DATE <b>1/27/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>MT AUBURN</b>		24D. LOCATION (City, town, or county) (State) <b>BALTO MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Brantham P. Hughes</b>		25D. ADDRESS <b>638 N. G. / m. 14</b>	

28-11-57

28-11-57

28-11-57

28-11-57

28-11-57

28-11-57

28-11-57

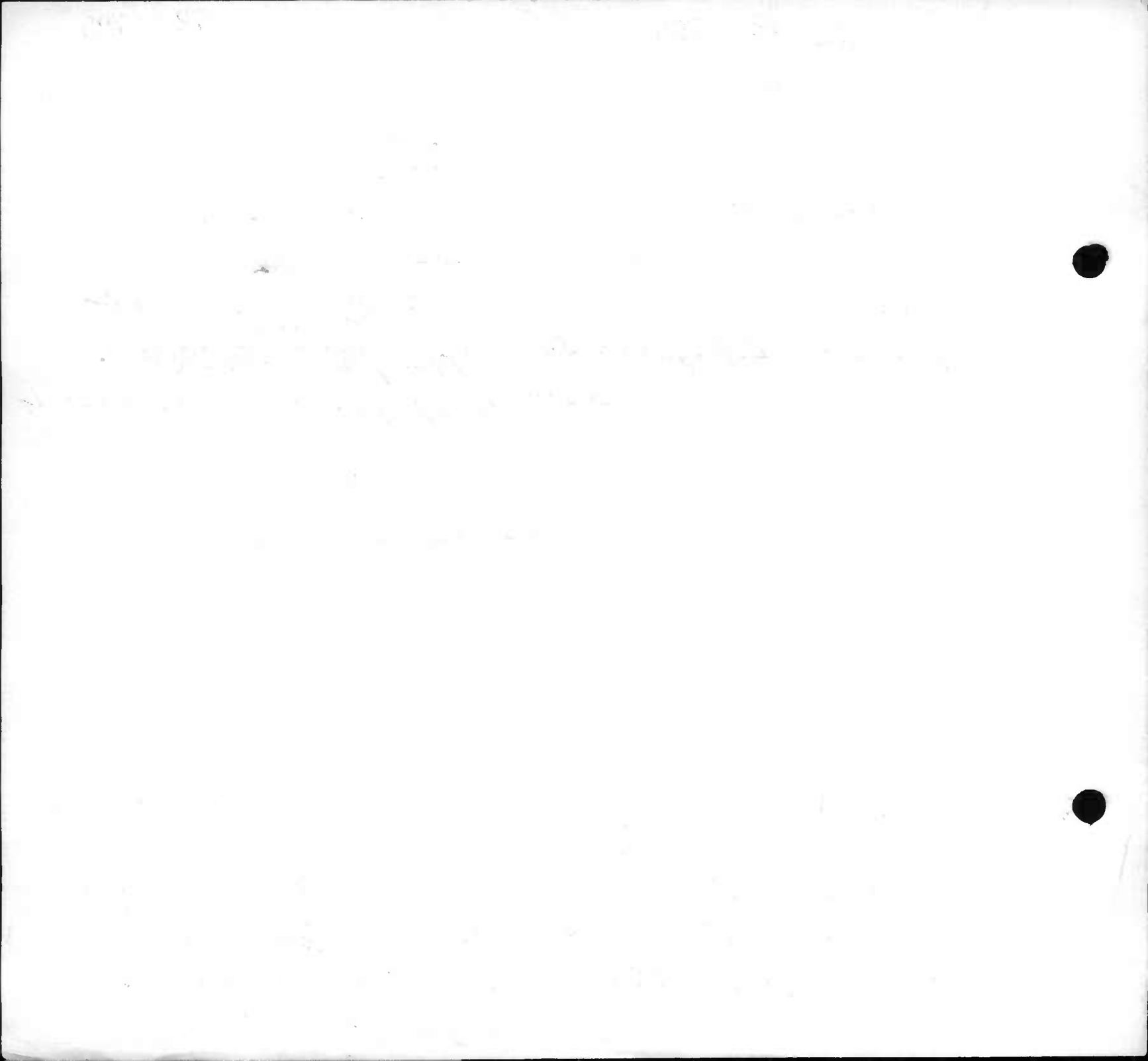
28-11-57

28-11-57

# FUNERAL DIRECTOR: IMPORTANT

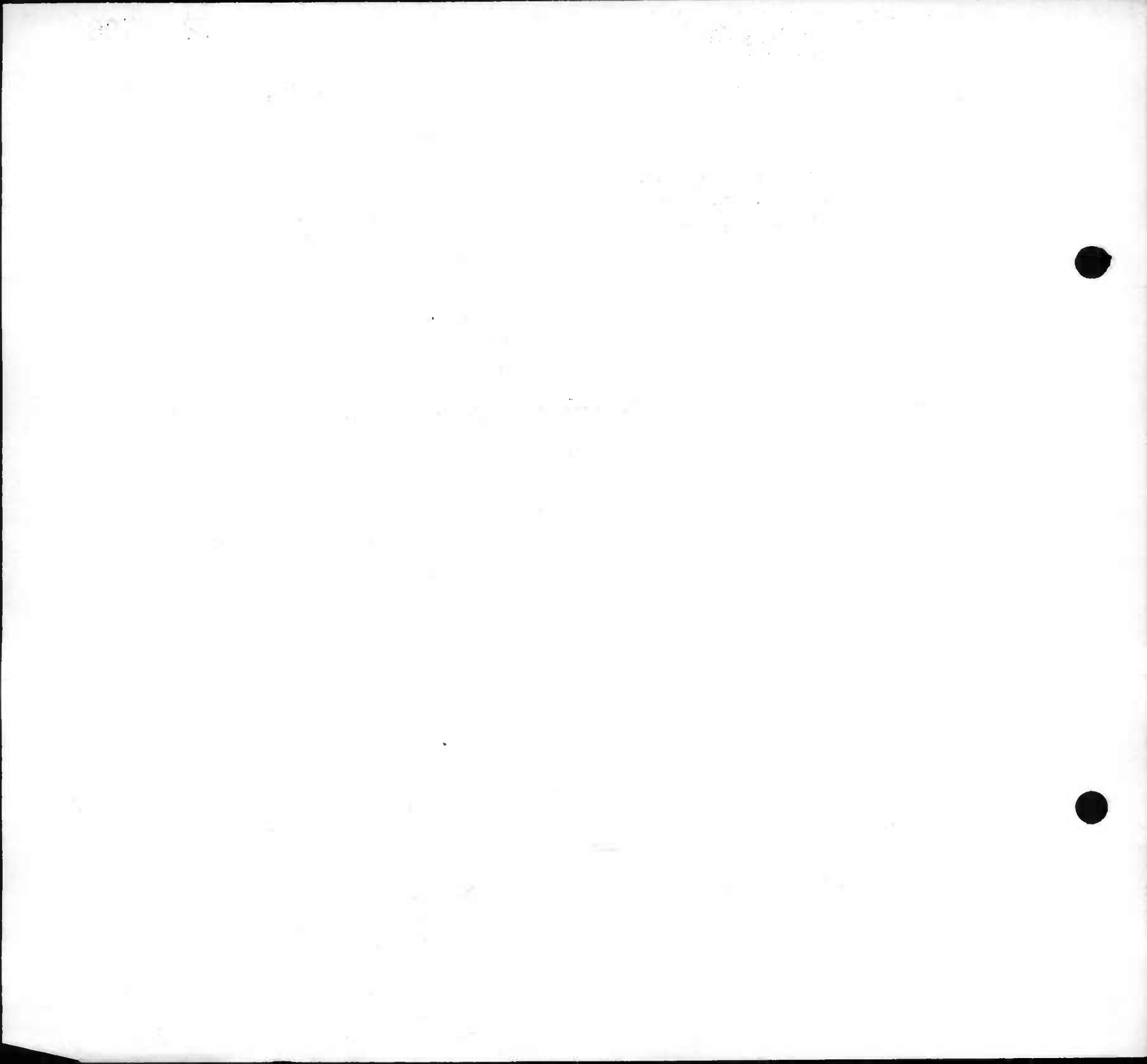
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span>B-535-72 00795</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> <span>72 00795</span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>		REG. NO. _____	
BIRTH NO. _____		2. DATE AND HOUR OF DEATH <u>JAN. 23 1972 17.05 P.M.</u>	
1. NAME OF DECEASED (Type or Print) <b>Bunting Hattie</b>		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md. Baltimore</b> B. COUNTY _____	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Provident Hospital</u>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2803 Garrison Blvd.</b>	
5. SEX <b>f</b>	6. RACE <b>B</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5-19-89</b>
9. AGE (In years last birthday) <b>82</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Rev. CHARLES H. PAYNTER Sr</b>		14. MOTHER'S MAIDEN NAME <b>Mrs. Mary Harris CORNER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) _____		16. SOCIAL SECURITY NO. <b>212-12-4427</b>	
17. INFORMANT <b>Mrs. Mary Harris 222 Fremont St</b>		ADDRESS _____	
18. <b>412.4 I</b> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>SEVERE ANEMIA</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>ATHEROSCLEROTIC C V DISEASE.</b>		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C) <b>R/O CVA.</b>		(C) _____	
II			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____	20A. AUTOPSY? (Yes or No) _____	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) _____	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <u>JAN 15 1972</u> to <u>JAN 23 1972</u> that (I) (we) last saw the deceased alive on <u>JAN 23 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Rayman G. Alley</b>		23B. DATE SIGNED <b>1/23/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Rayman G. Alley</b>		23D. ADDRESS <b>PROVIDENT HOSP INC.</b>	
24A. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	24B. DATE <b>1/24/72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>ROOSEVELT MEM PH</b>	24D. LOCATION (City, town, or county) (State) <b>465 ADAMS VA</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>	25B. NAME OF REGISTRAR <b>Robert E. Taylor</b>	25C. FUNERAL DIRECTOR <b>638 N. C. L. M. M.</b>	ADDRESS _____



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

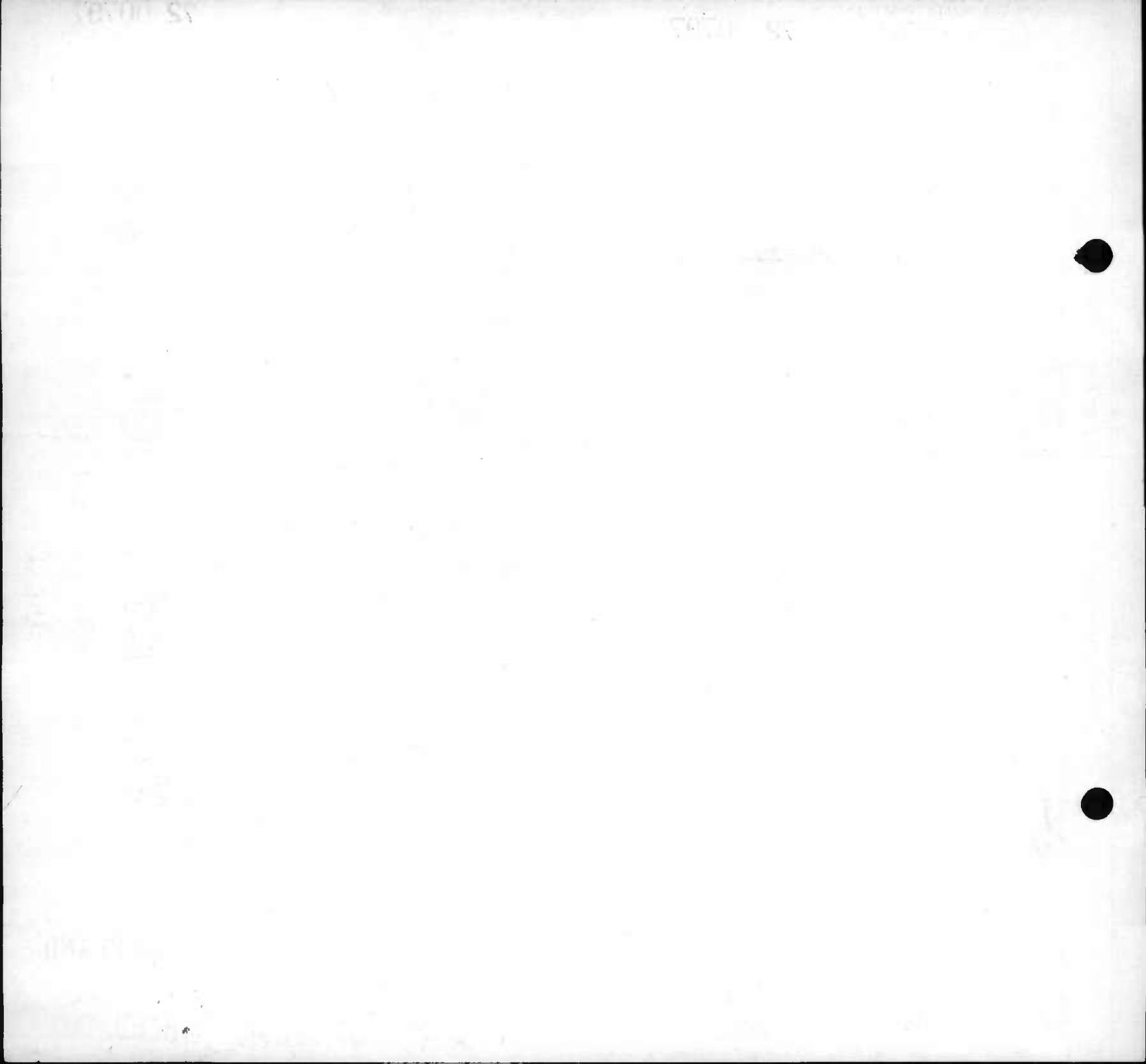
J-525		72 00796		BALTIMORE CITY HEALTH DEPARTMENT		72 00796	
BIRTH NO.		72 00796		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) Robert JOHNSON				2. DATE AND HOUR OF DEATH Jan 18, 1972 8:00 A.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION 90 Midtown Home, Inc. 808 St. Paul Street Baltimore, Maryland 21202				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 1602 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 918 N Stricker St			
5. SEX M	6. RACE B	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4/27/71	9. AGE (In years last birthday) 100	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Not known		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) CALVERT CO MD		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Robert Johnson				14. MOTHER'S MAIDEN NAME Annet Woods			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 19-16-1290		17. INFORMANT Sophie Tyson 918 N Stricker St		ADDRESS	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 4/27/71 105X ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH Cardio Respiratory Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Arteriosclerotic CVD (B) Carcinoma of the Prostate DUE TO, OR AS A CONSEQUENCE OF: (C) Gen & Cor Blood Arteriosclerosis			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from December 1, 1971 to January 18, 1972 that (I) (we) last saw the deceased alive on Jan 18, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.							
23A. SIGNATURE William D Appleford				23B. DATE SIGNED			
23C. PHYSICIAN'S NAME (Type) William D Appleford				23D. ADDRESS 6615 Neustadter Rd			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/24/72		24C. NAME OF CEMETERY or CREMATORY St Johns Church		24D. LOCATION (City, town, or county) I State Lusby MD	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1972		25B. NAME OF REGISTRAR Robert E. Taylor		25C. FUNERAL DIRECTOR Mark H. Hays		ADDRESS 688 N. ...	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				Registered No. 72 00797	
CERTIFICATE OF DEATH					
M-250 72 00797		72 00806			
M.E. CASE NO. 72-00806					
1. NAME OF DECEASED (Type or Print) <i>Antonio Eric McKenney</i>		2. DATE AND HOUR OF DEATH <i>11/13/72 9<sup>25</sup> A M.</i>			
3. PLACE OF DEATH IN BALTIMORE, MARYLAND		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>MD</i> B. COUNTY <i>1703</i>			
FULL NAME OF HOSPITAL OR INSTITUTION <i>MD. General Hosp.</i>		C. CITY OR TOWN (If outside city limits, write RURAL and give township) <i>Balto</i>			
		D. STREET ADDRESS (If rural, give location) <i>1013 Argyle Ave 21201</i>			
5. SEX <i>Male</i>	6. RACE <i>Negro</i>	7. MARRIED, NEVER MARRIED WIDQWED, DIVORCED (specify)	8. DATE OF BIRTH <i>1-7-72</i>	9. AGE (In years last birthday) <i>5</i>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <i>Eugene Victor Bay, Jr.</i>			
14. MOTHER'S MAIDEN NAME <i>Darlene Bonnie McKenney</i>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mother</i> ADDRESS <i>1013 Argyle Ave</i>			
18. 778.91 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) <i>Prematurity</i> (B) <i>Cardiac arrest</i> (C)		INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING IT.					
19A. DATE OF OPERATION <i>2</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <i>Yes</i>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>11/7/72</i> 19 to <i>11/13/72</i> 19, that (I) (we) last saw the deceased alive on <i>11/13/72</i> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Russ Berlin</i>		M.D. Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <i>11/15/72</i>	
23C. PHYSICIAN'S NAME (Type) <i>Gino F. Z. Z. R. B. I. N. M.D.</i>		23D. ADDRESS <i>6637 Loch Raven Blvd. Baltimore, Md. 21239</i>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <i>1-20-72</i>		24C. NAME OF CEMETERY or CREMATORY <b>ANATOMY BOARD OF MARYLAND</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <i>Robert E. Taylor, M.D.</i>		25C. FUNERAL DIRECTOR <b>UNIVERSITY MEDICAL SCHOOL</b>	
<b>MORTUARY SERVICE - BCHD</b>					

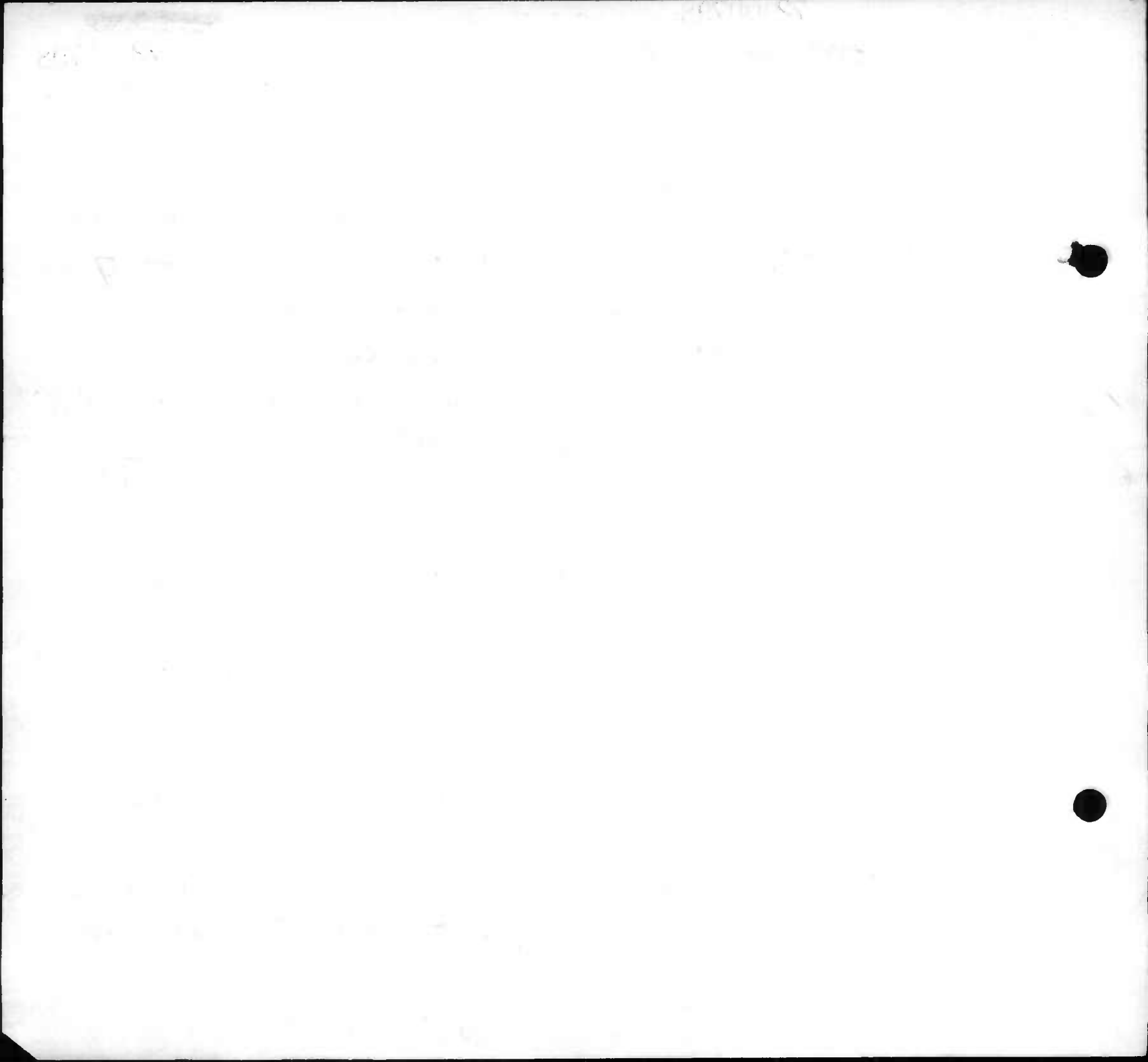




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

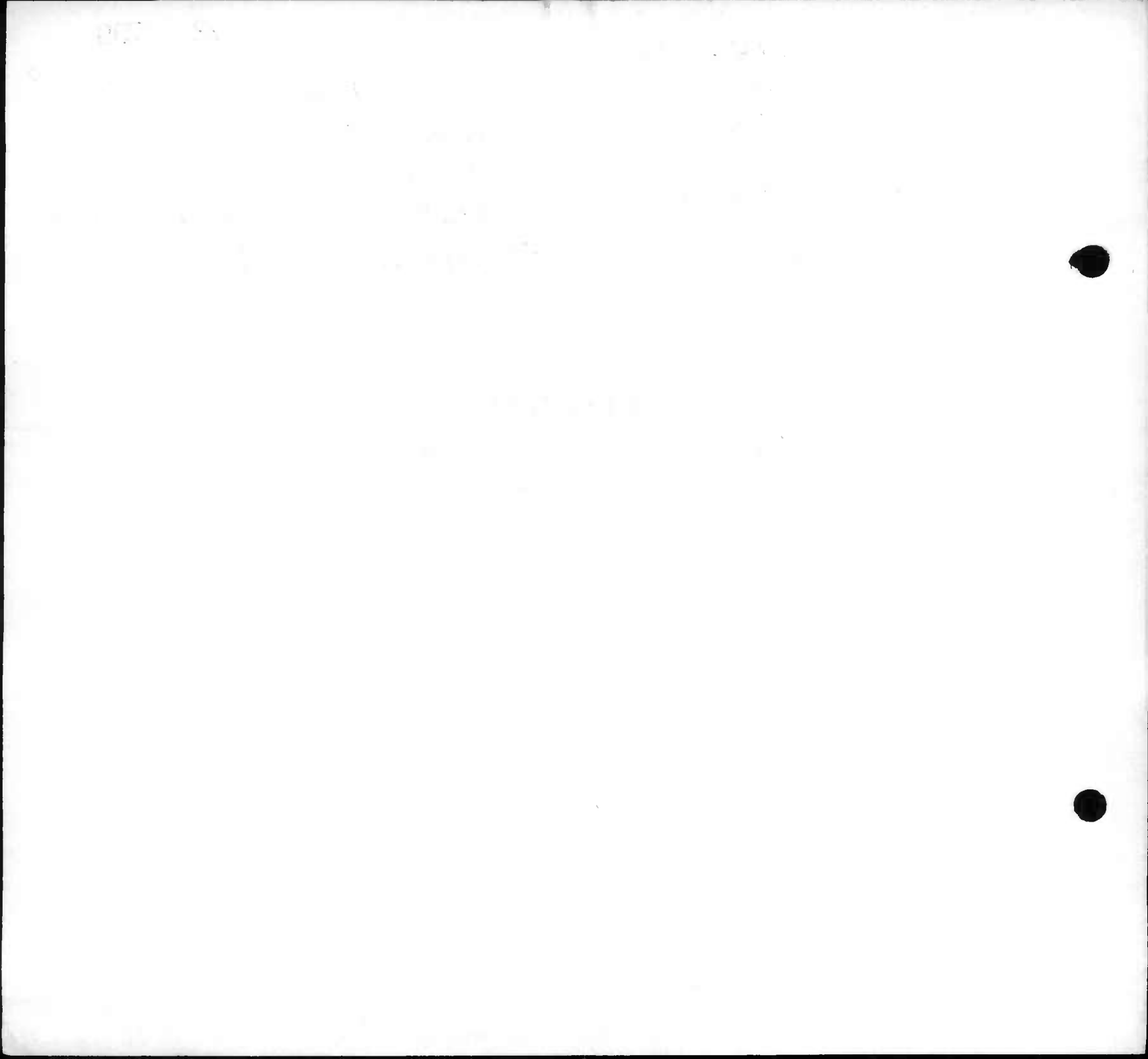
BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH				REG. NO. <u>72 00798</u>
1. NAME OF DECEASED (Type or Print) <u>LIM BABY BOY LIM</u>		2. DATE AND HOUR OF DEATH <u>1-19-72</u> <u>7:45 A</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>CHURCH HOME AND HOSPITAL</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>BALTO. AA</u> <u>5200</u>		
5. SEX <u>M</u>		6. RACE <u>ORIENTAL</u>		7. AGE (In years last birthday) <u>1-13-72</u>
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. If Under 1 Yr. Months Days <u>8</u> If Under 24 Hrs. Hours Min. <u>45</u>		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NEWSBOY</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (State or foreign country) <u>BALTO - MD.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>		13. FATHER'S NAME <u>LIM YU CHAN</u>		
14. MOTHER'S MAIDEN NAME <u>LIM CHUEN SHANG</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		
16. SOCIAL SECURITY NO.		17. INFORMANT <u>PARENTS</u> ADDRESS <u>1620 PLEASANTVILLE Dr. GLEN BORO MD.</u>		
18. <u>776-21</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <u>APNEIC SPELLS,</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>(A) IMMEDIATE CAUSE METABOLIC ACIDOSIS</u> <u>(B) RESPIRATORY DISTRESS SYNDROME</u> <u>(C) PREMATURITY - IMMATURITY</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>7h 45min</u>		
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?
22. I certify that (I) (this hospital) attended the deceased from <u>1-18</u> <u>1972</u> to <u>1-19</u> <u>1972</u> that (I) (we) lost saw the deceased alive on <u>1-19</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.				
23A. SIGNATURE <u>E. CONTRERAS</u>		23B. DATE SIGNED <u>1-19-72</u>		23C. PHYSICIAN'S NAME (Type) <u>E. CONTRERAS</u>
23D. ADDRESS <u>6128 EAST PEARL ST. BALTO MD.</u>		24. BURIAL CREMATION, REMOVAL (Specify)		
24B. DATE <u>1-20-72</u>		24C. NAME of CEMETERY or LOCATION <u>ANATOMY BOARD OF MARYLAND</u>		
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>		
25C. FUNERAL DIRECTOR <u>MORTUARY SERVICE - BCHD</u>				



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00799</b>	
BIRTH NO. <b>72 00799</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>FREDERICK A. JACKSON</b>		2. DATE AND HOUR OF DEATH <b>1/12/72</b> <b>230</b> P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>34 BON SECOURS HOSPITAL</b> IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>M.D.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>842 1/2 W. LOMBARD ST. BAL. 1</b>	
5. SEX <b>M</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/11/03</b>
9. AGE (In years last birthday) <b>78</b>		10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]		16. SOCIAL SECURITY NO. <b>212-09-8697</b>	
17. INFORMANT		ADDRESS	
18. <b>519.3 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Acute Respiratory insufficiency</b> DUE TO, OR AS A CONSEQUENCE OF: <b>Spontaneous pneumothorax</b> (B) <b>Chronic obstructive lung Disease</b> DUE TO, OR AS A CONSEQUENCE OF: (C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <b>(H)</b> (this hospital) attended the deceased from <b>January 10 1972</b> to <b>January 12 1972</b> that <b>(H)</b> (we) last saw the deceased alive on <b>January 12 1972</b> and that in <b>(my)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(H)</b> (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Thien Thiti Varana</b> M.D. DEGREE		23B. DATE SIGNED	
23C. PHYSICIAN'S NAME (Type) <b>THIEN THITI VARANA</b> M.D. DEGREE		23D. ADDRESS <b>BON SECOURS HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-17-72</b>	
24C. NAME OF CEMETERY or CREMATOR		24D. LOCATION	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Talley, R.D.</b>	
25C. HEALTH OFFICER		25D. ADDRESS	

ANATOMY BOARD OF MARYLAND  
UNIVERSITY MEDICAL SCHOOL  
MORTUARY SERVICE - BCHD



P-620

72 00800

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00800

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

RONALD POWERS

2. DATE  
OF  
DEATHKnown ☐  
Estimated ☐

Month

Day

Year

Hour

M.

4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL  
OR INSTITUTION(If not in hospital or institution, give street  
address or location)

437 N. Robinson St.

3. DATE  
PRONOUNCED DEAD

Month

Day

Year

Hour

M.

1

23

1972

10 p

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE

Md.

B. COUNTY

6. SEX

male

7. RACE

white

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

Oct. 24, 1954

10. AGE (In years  
last birthday)

17

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

437 N. Robinson St.

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF  
WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Louis Powers

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Printer

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Lucile Hayes

16. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL  
SECURITY NO.

215-66-0493

18. INFORMANT

ADDRESS

L. Powers 437 N. Robinson St.

19.

304.91

CAUSE OF DEATH

Intravenous narcotism

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asthma, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

MEDICAL CERTIFICATION

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY  
(APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATURE  
EXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-24-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

Burial

24B. DATE

1-27-72

24C. NAME of CEMETERY or CREMATORY

Oak Lawn Cemetery

24D. LOCATION (City, town, or county)

Balto. Md.

(State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1972

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

B. Dabrowski 2818 E. Balto. St.

000000

000000



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

W-650		72 00801		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. 72 00801	
1. NAME OF DECEASED (Type or Print) <u>Emma Warren</u>				2. DATE AND HOUR OF DEATH <u>1-23-72</u> <u>1:20 PM</u> M.					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>CITY</u>					
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>BALTIMORE, MD 21205</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER <u>502 ROUNDVIEW ROAD</u> <u>21225</u>					
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12-13-09</u>		9. AGE (In years last birthday) <u>62</u>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>MD.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>WILLIAM HOLMES</u>				14. MOTHER'S MAIDEN NAME <u>EMMA ASKINS</u>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Luther Warren-502 Roundview Rd.</u>				ADDRESS	
18. <u>59321</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Pseudomonas Sepsis</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>End Stage Kidney disease</u>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pseudomonas Sepsis</u> (B) <u>End Stage Kidney disease</u> DUE TO, OR AS A CONSEQUENCE OF: (C) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>	
II									
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <u>1-23-72</u> 19 to <u>1-23-72</u> 19 that (I) (we) last saw the deceased alive on <u>1-23-72</u> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <u>M. Horan MD</u>				23B. DATE SIGNED				23C. PHYSICIAN'S NAME (Type) <u>M. HORAN M.D.</u>	
23D. ADDRESS <u>Johns Hopkins Hosp</u>									
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-27-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Carver Mem. Park</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Md. 21205</u>			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1972</u>		25B. NAME OF REGISTRAR <u>Robert J. ...</u>		25C. FUNERAL DIRECTOR <u>Milton E. Elickson</u> ADDRESS <u>1129 N. Caroline St.</u>					

Count of the ...

11-11-11

11-11-11

11-11-11

11-11-11

11-11-11

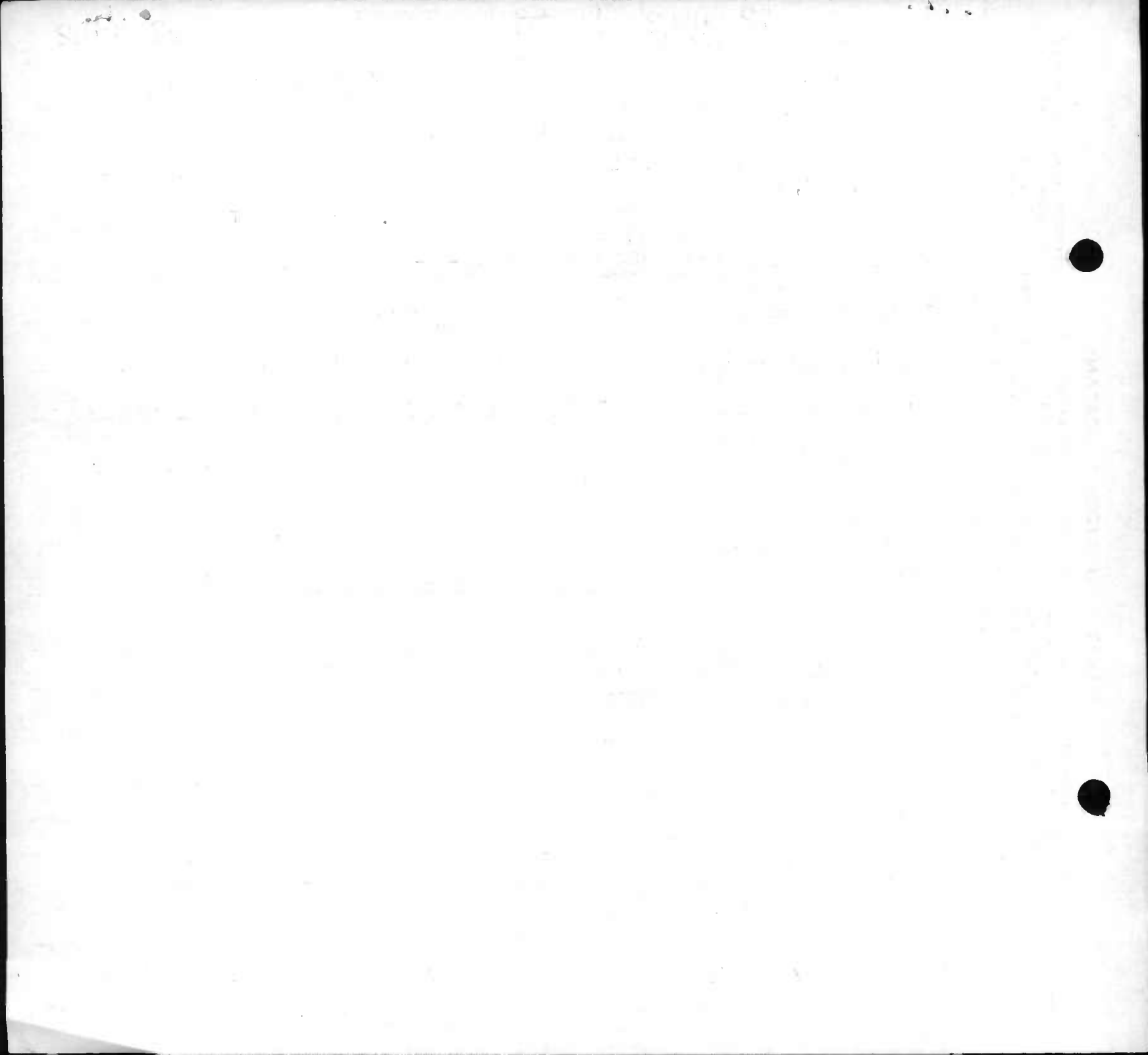
11-11-11



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. 72 00802	
1-520 72 00802		CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) <u>Mary Jones</u>		2. DATE AND HOUR OF DEATH <u>1/23/72 12:30 AM</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1001</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>THE JOHNS HOPKINS HOSPITAL</u> <u>33</u> BALTIMORE, MD 21205		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER <u>714 E. CHASE STREET</u>					
5. SEX <u>FEMALE</u>	6. RACE <u>NEGRO</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>05-07-06</u>	9. AGE (In years last birthday) <u>65</u>	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>VA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>CHRISTOPHER WILKINS</u>			
14. MOTHER'S MAIDEN NAME <u>ELIZABETH ?</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>			
16. SOCIAL SECURITY NO. <u>217-05-3536</u>		17. INFORMANT <u>Mary Hamell - 714 E. Chase St.</u>			
18. <u>153.8 I</u>		CAUSE OF DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Cardio pulmonary arrest 2 hrs</u>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <u>Myocardial Infarction 24 hrs</u> (C) <u>Post op drainage of abscess</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>Cu y Celon</u>			
19A. DATE OF OPERATION <u>1/21/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>abd. abscess</u>		20A. AUTOPSY (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/17/72</u> 19__ to <u>1/23/72</u> 19__ that (I) (we) last saw the deceased alive on <u>1/23/72</u> 19__ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Michael Zinn</u>		23B. DATE SIGNED <u>1/23</u>		23C. PHYSICIAN'S NAME (Type) <u>MICHAEL Zinn M.D.</u>	
23D. ADDRESS <u>J. H. H.</u>					
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-27-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Int. Calvary Cemetery</u>	
24D. LOCATION (City, town, or county) (State) <u>A.A. County, Md.</u>					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>		25C. FUNERAL DIRECTOR <u>Robert E. Taylor - 11297 Caroline St.</u>	



72 00803

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00803

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>WILLIS KING</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>1718 Holbrook Street</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 20, 1972 9:30 A.M.</b>	
5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>909</b>			
6. SEX <b>Male</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. CITY OR TOWN <b>Baltimore</b>
10. AGE (in years last birthday) <b>11-19-20 51</b>		11. DATE OF BIRTH <b>11-19-20</b>	
12. BIRTHPLACE (State or foreign country) <b>md.</b>		13. CITIZEN OF <b>U.S.A.</b>	
14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>unemployed - laborer</b>		15. KIND OF BUSINESS OR INDUSTRY <b>unemployed - laborer</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (if yes, give war or dates of service) <b>yes W.W.II.</b>		17. SOCIAL SECURITY NO.	
18. INFORMANT <b>James Howard - 57# 15th Ave.</b>		ADDRESS	
19. <b>431-71</b>		CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE <b>Massive intracerebral hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?		22D. TIME OF INJURY (APPROX.)	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Charles S. Springate</b> EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>January 20, 1972</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-25-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>St. Stephens Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Farber, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Wm. O. Clifton</b>		ADDRESS <b>1139 N. Carroll</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 00804				BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00804	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
Foster, Charles L.				1/20/72		12:45 M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION 35 Church Home and Hospital Broadway and Fayette St.				A. STATE Md.		B. COUNTY 665	
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 1439 Mullikin Ct., 21231							
5. SEX male	6. RACE negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1880	9. AGE in years (last birthday) 91	If Under 1 Yr. Months: Days		If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY
13. FATHER'S NAME Dennis Foster			14. MOTHER'S MAIDEN NAME Unknown				
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Janice Foster 1439 Mullikin Ct		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH 486X I (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			CAUSE OF DEATH (A) IMMEDIATE CAUSE pneumonia, heart failure DUE TO, OR AS A CONSEQUENCE OF:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(B) old age? DUE TO, OR AS A CONSEQUENCE OF:				
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION 0		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 8:55 PM 1-19-1972 to 12:45 PM 1-19-1972 that (I) (we) last saw the deceased alive on 12 PM 1-19-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE R. Sajadi				23B. DATE SIGNED 1-19-72			
23C. PHYSICIAN'S NAME (Type) R. SAJADI				23D. ADDRESS CH & H			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE 1-24-72		24C. NAME OF CEMETERY OR CREMATORY Mt. Calvary Em. A.A. Co.		24D. LOCATION (City, town, or county) (State) Md.	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1972		25B. NAME OF REGISTRAR J. E. Taylor		25C. FUNERAL DIRECTOR Raymond Sanders		25D. ADDRESS 2176 Preston St	



72 00805

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00805

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

GARRY LEE MORGAN

2. DATE OF DEATH Known ☐ Month Day Year Hour  
Estimated ☐ M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

46 Lutheran Hospital

3. DATE PRONOUNCED DEAD Month Day Year Hour  
1 23 1972 11:50 a.m.5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Md.

1510

6. SEX

male

7. RACE

negro

8. MARRIED ☐ NEVER MARRIED ☒WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Balto.

D. INSIDE CITY LIMITS?

YES ☒NO ☐

9. DATE OF BIRTH

2-15-51

10. AGE (In years  
last birthday)

20

If Under 1 Yr. If Under 24 Hrs.  
Months Days Hours Min.

E. STREET AND NUMBER

4011 Oakford Ave.

11. BIRTHPLACE (State or foreign country)

Md.

12. CITIZEN OF  
WHAT COUNTRY?  
U.S.A.

13. FATHER'S NAME

Lee O. Morgan

14A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

Orderly

14B. KIND OF BUSINESS OR INDUSTRY

15. MOTHER'S MAIDEN NAME

Shirley Brown

16. WAS DECEASED EVER IN U.S. ARMED FORCES?  
(Yes, no or unknown) (If yes, give war or dates of service)

no

17. SOCIAL  
SECURITY NO.

18. INFORMANT

ADDRESS

Shirley Morgan

same

19.

304.9

CAUSE OF DEATH

Intravenous narcotism

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, IF ANY, GIVING  
RISE TO THE ABOVE CAUSE (A) STATING THE  
UNDERLYING CONDITION LAST.

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

MEDICAL CERTIFICATION

II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART 1 (A).

20A. DATE OF OPERATION

2

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

yes

22A. EXTERNAL CAUSE WAS  
UNDERLYING ☐ OR CONTRIB-  
UTING ☐ CAUSE OF DEATH.22B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg., etc.)22C. WHERE DID (If in Baltimore City, give exact location)  
INJURY OCCUR?22D. TIME (Month) (Day) (Year) (Hour)  
OF INJURY (APPROX.)

22E. INJURY OCCURRED

WHILE AT  
WORK ☐NOT WHILE  
AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion  
resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL  
SIGNATUREEXAMINER'S  
NAME (Type)

Russell S. Fisher, M.D.

CHIEF MEDICAL EXAMINER ☒ASSISTANT MEDICAL EXAMINER ☐ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-24-72

24A. BURIAL CREMATION,  
REMOVAL (Specify)

burial

24B. DATE

1-28-72

24C. NAME of CEMETERY or CREMATORY

New Cathedral Cem.

24D. LOCATION (City, town, or county) (State)

Baltimore, Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1972

25B. NAME OF REGISTRAR

Robert E. Fisher, M.D.

25C. FUNERAL DIRECTOR

Nelson F.H. Bailey ADDRESS

1348 Calhoun Street

0.5 1.0 1.5 2.0



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 00806		72 00806	
BIRTH NO.		72 00806		72 00806	
1. NAME OF DECEASED (Type or Print) <u>Benton West</u>			2. DATE AND HOUR OF DEATH <u>1-22-72</u> <u>10:55 A.M.</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>Bolton Hill Nursing Home</u>			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD</u> B. COUNTY <u>805</u>		
5. SEX <u>Male</u>			6. RACE <u>Black</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>
13. FATHER'S NAME <u>BENJAMIN WEST</u>			14. MOTHER'S MAIDEN NAME <u>ELIZ CARTER</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>			16. SOCIAL SECURITY NO. <u>216-10-9213</u>		17. INFORMANT <u>DOROTHY WASHINGTON</u> ADDRESS <u>Medical Records 1727 DARLEY AVE.</u>
18. <u>4/2/3 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE <u>auto accident</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>auto accident</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>chronic brain syndrome</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>years</u> <u>years</u> <u>years</u>
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/10</u> 19 <u>72</u> to <u>1/22</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/22</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>[Signature]</u>			23B. DATE SIGNED <u>1/24/72</u>		23C. PHYSICIAN'S NAME (Type) <u>DR. H. MACHT MD</u>
24A. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>			24B. DATE <u>1-25-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>MT. AUBURN Cem.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1972</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, MD.</u>		25C. FUNERAL DIRECTOR <u>O. BAILEY</u> ADDRESS <u>1348 CALHOUN ST.</u>

1. The first of these is the

2.

3.

4.

5.

6.

7.

and the other is the

8.

9.

10.

11.

12.

13.

14.

15.

16.

17.

18.

19.

20.

21.

1  
D120

## BALTIMORE CITY HEALTH DEPARTMENT

72 00807

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00807

BIRTH NO. 71-10255

1. NAME OF DECEASED (Type or Print) <b>GERMAINE DAVIS</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> Month Day Year	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>MARYLAND GENERAL HOSPITAL (DOA)</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 22, 1972</b> Hour: <b>2:55 P.</b>	
6. SEX <b>Female</b>	7. RACE <b>Negro</b>	5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1702</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>6-18-71</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) <b>7</b>		E. STREET AND NUMBER <b>1204 Division Street</b>	
11. BIRTHPLACE (State or foreign country) <b>Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jerome Davis</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY	
15. MOTHER'S MAIDEN NAME <b>Irene Harris</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Jerome Davis</b>	
19. <b>746.4</b>		ADDRESS <b>1204 Division St.</b>	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Bronchopneumonia</b>		CAUSE OF DEATH <b>Bronchopneumonia</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>Congenital heart disease (Intra-atrial septal defect)</b>		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Congenital heart disease (Intra-atrial septal defect)</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		(B) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>		22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	
22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME (Month) (Day) (Year) (Hour) (Approx.)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?		23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>	
ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>	
DATE SIGNED <b>1/23/72</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	
24B. DATE <b>1-25-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>	
25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>V. Bailey</b>	
25D. ADDRESS <b>Kelson B.H. 1348 Calhoun Street</b>			

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

7049 55 7049 55

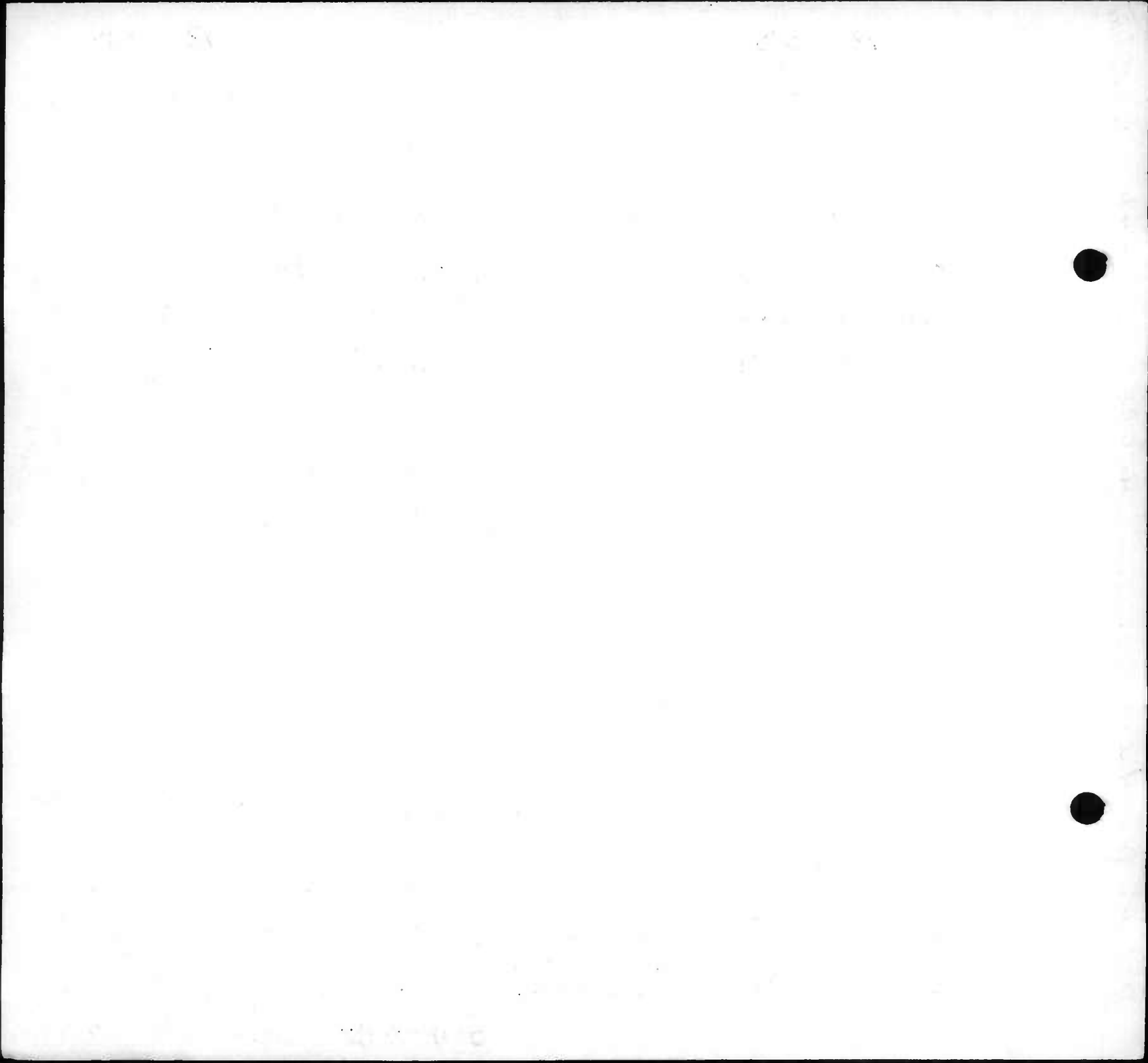
7049 55 7049 55

Release for Medical Examiner - Mr. GREGORY TOWNE  
Baltimore  
S 2201

FUNERAL DIRECTOR: IMPORTANT

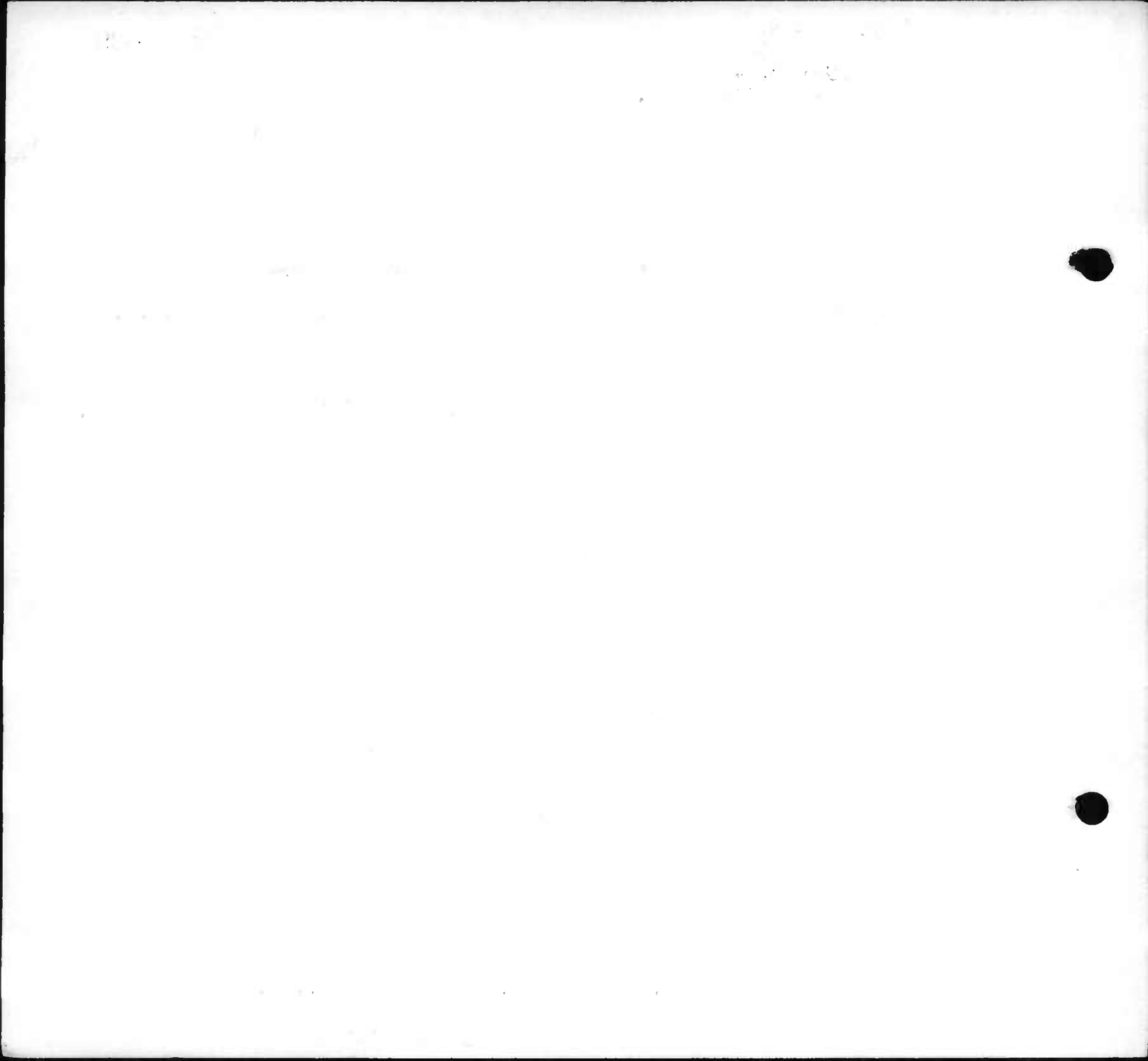
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. 72 00808		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00808	
1. NAME OF DECEASED (Type or Print) SYKES, BEATRICE M.		2. DATE AND HOUR OF DEATH 1-22-1972 3:30 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) UNION MEMORIAL HOSPITAL		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY 905 C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 1141 GORSUCH AVE			
5. SEX F	6. RACE N	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/21/1927	9. AGE (in years last birthday) 44	If Under 1 Yr. Months: Days: Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland	
13. FATHER'S NAME John Hines		14. MOTHER'S MAIDEN NAME Emma Harding			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
18. 436.01 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: CEREBRO VASCULAR ACCIDENT. (B) Hypertension. DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 1-22-1972 to 1-22-1972 that (I) (we) last saw the deceased alive on 1-22-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE [Signature] MD		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED 1-22-72	
23C. PHYSICIAN'S NAME (Type) PORTER A. BATTISONE MD		23D. ADDRESS UNION MEMORIAL HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/72		24C. NAME OF CEMETERY OR CREMATORY [Signature] Cemetery, Baltimore, Md	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1972		25B. NAME OF REGISTRAR Robert E. [Signature]		25C. FUNERAL DIRECTOR [Signature] 2463 Druid Hill Ave	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

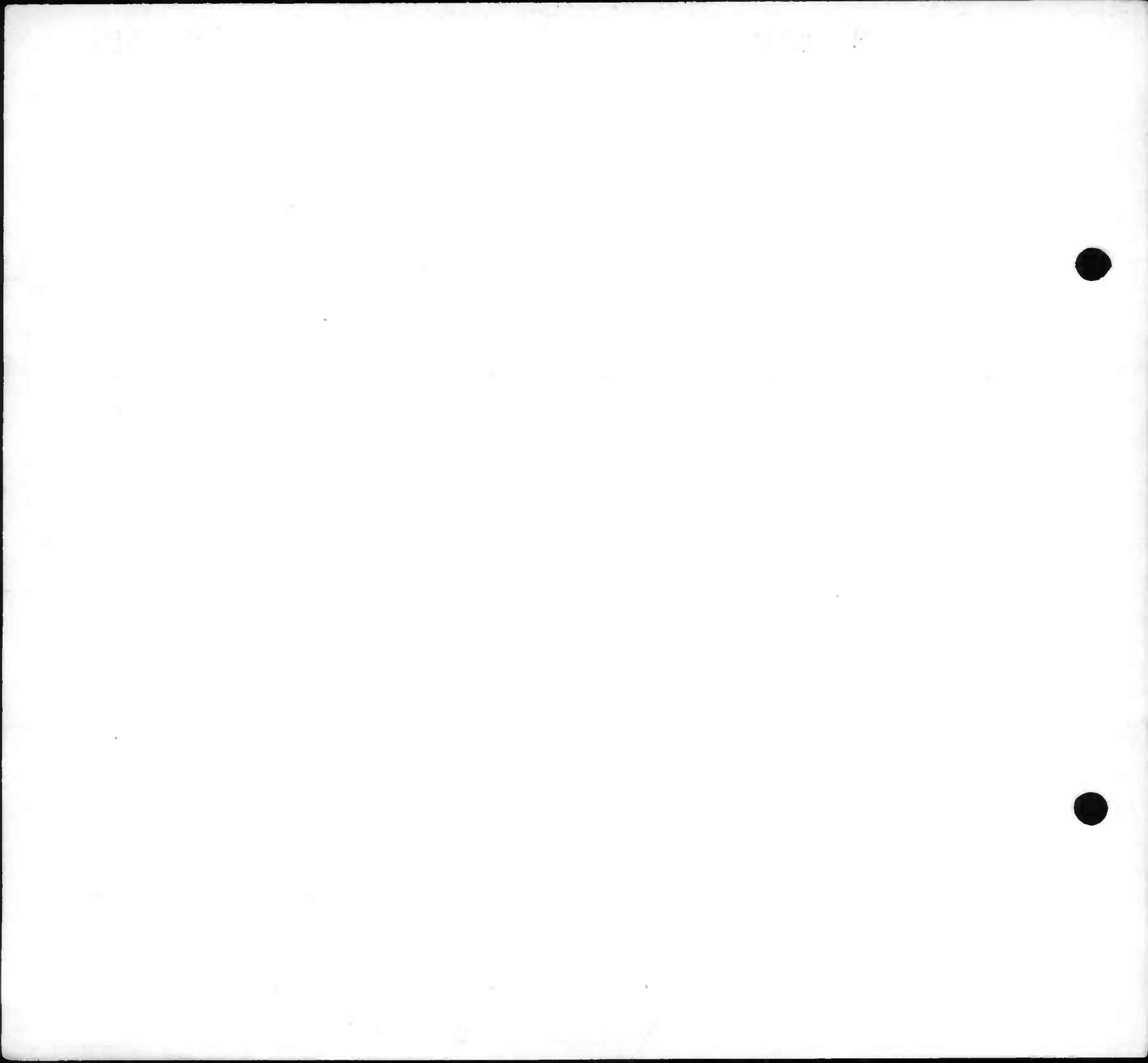
72 00809		BALTIMORE CITY HEALTH DEPARTMENT <b>CERTIFICATE OF DEATH</b>		REG. NO. 72 00809	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		Candace Flora M. Davis		11/22/72 9:50 a.m.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)			A. STATE B. COUNTY		
Lutheran Hospital of Md.			Md. 1502		
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	
F		N		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH	
Housewife				8-23-02	
11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?		9. AGE (In years last birthday)	
S.C.		U.S.A.		69	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
no				Rev. John Davis 3404 Edgewood Rd.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
482.91 Pneumonitis with septic shock					
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES				(B) DUE TO, OR AS A CONSEQUENCE OF:	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
(Month) (Day) (Year) (Hour)		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 11/11/72 to 11/22/72 and that (I) (we) last saw the deceased alive on 11/21/72 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Anjana Doshti M.D.				11/22/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
ANJANA DOSHTI M.D.					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1-27-72		Mt. Auburn Cem.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 25 1972		Robert E. Bailey M.D.		V. Bailey	
				ADDRESS	
				1348 Calhoun Street	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <b>72 00810</b>	
BIRTH NO. <b>72 00810</b>				1. NAME OF DECEASED (Type or Print) <b>Mr. Paul J. Smith</b>		2. DATE AND HOUR OF DEATH <b>1-24-72 3:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  <b>Box Secours Hospital</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2802</b>			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Box Secours Hospital</b>				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>4504 Maine Ave.</b>			
5. SEX <b>M</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/18/13</b>		9. AGE (In years last birthday) <b>58</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Worker</b>			10B. KIND OF BUSINESS OR INDUSTRY <b>Bethlehem Steel</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Wes Smith</b>				14. MOTHER'S MAIDEN NAME <b>LISA Yearly</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service <b>no</b>			16. SOCIAL SECURITY NO. <b>218-03-4659</b>		17. INFORMANT <b>Lorraine Smith</b> ADDRESS <b>4504 Maine Ave.</b>		
18. <b>150X I</b> CAUSE OF DEATH						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last,				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Cancer of Esophagus</b> (B) <b>Generalized Metabolism</b> DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>01-20-72</b> 19 <b>72</b> to <b>01-24</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1-24-</b> 19 <b>72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Marco Florez</b> MD DEGREE				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1-24-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARCO FLOREZ</b> MD DEGREE				23D. ADDRESS <b>20 25 W FAYETTE ST BALTIMORE MD</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-28-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cem.</b>		24D. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>John E. Feltz, MD</b>		25C. FUNERAL DIRECTOR <b>Kelson O. Ho</b>		ADDRESS <b>1348 Calhoun Street</b>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

72 00811

BIRTH NO.

72 00811

1. NAME OF DECEASED

(Type or Print)

SAYLES, Ollie

2. DATE AND HOUR OF DEATH

1-21-72 9 45 PM

M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION

Provident Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)

A. STATE

B. COUNTY

MARYLAND

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

2118 N. Smallwood St

5. SEX

FEMALE

6. RACE

NEGRO

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☐

8. DATE OF BIRTH

9-24-06

9. AGE (In years last birthday)

65

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

Willie Fowlkes

14. MOTHER'S MAIDEN NAME

Missouri Marshall

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown) no

(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

911-18-6821

17. INFORMANT

ADDRESS

Richard Sayles 2118 Smallwood St.

18.

250.01

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

ASHD e Ac. Left heart failure + A. Fibroses

(B)

DUE TO, OR AS A CONSEQUENCE OF:

Diabetes mellitus a non-Ketotic Hyperosmolarity

(C)

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_ that (I) (we) last saw the deceased alive on \_\_\_\_\_ 19\_\_\_\_ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

M. C. MERCADO

DEGREE

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-21-72

23C. PHYSICIAN'S NAME (Type)

M. C. MERCADO

DEGREE

23D. ADDRESS

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1-27-72

24C. NAME of CEMETERY or CREMATORY

Family Plot

24D. LOCATION

(City, town, or county)

(State)

Nottoway Co., Va.

25A. DATE REC'D BY HEALTH DEPT.

JAN 25 1972

25B. NAME OF REGISTRAR

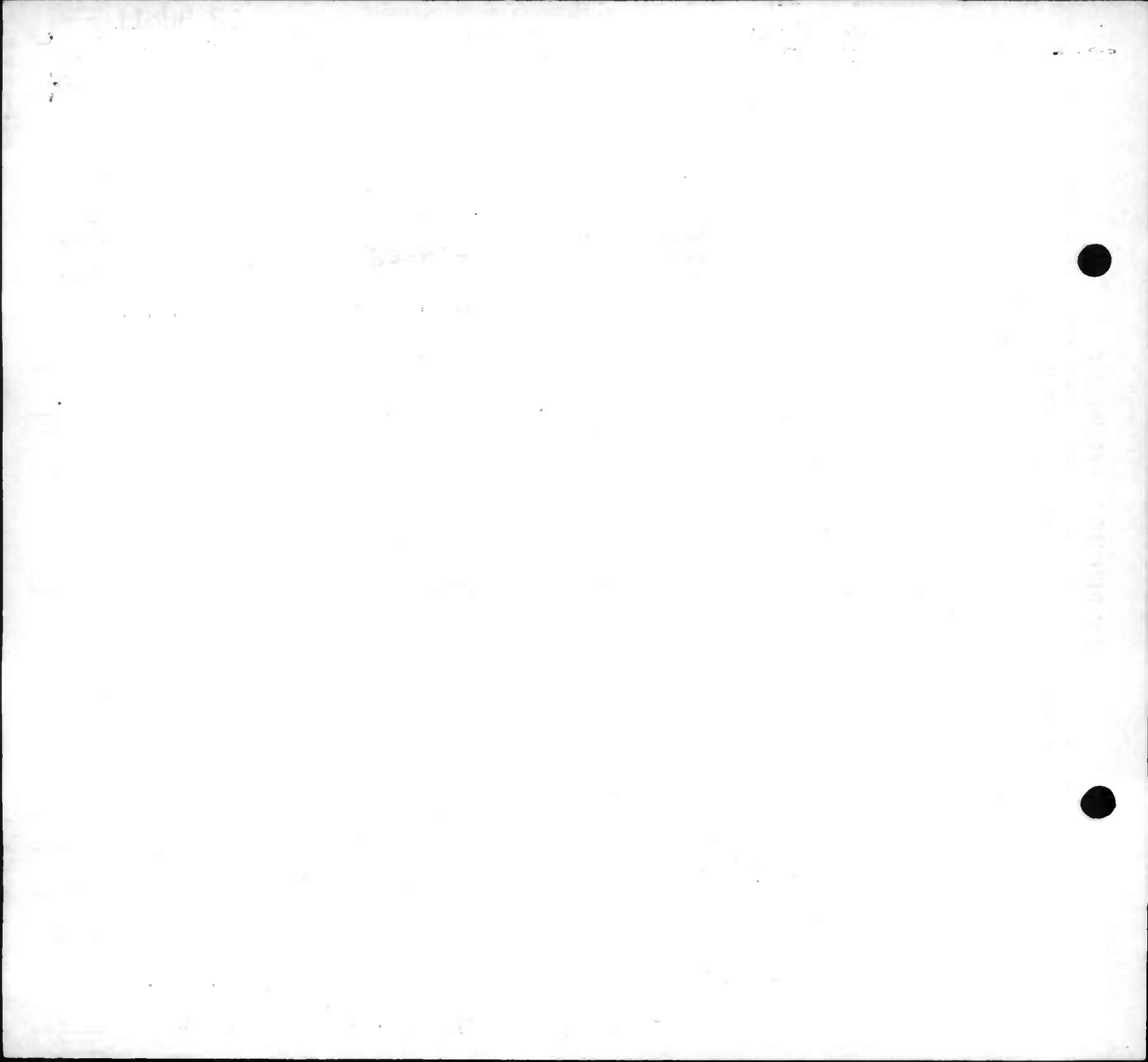
R. E. Fabley, M.D.

25C. FUNERAL DIRECTOR

V. Bailey

ADDRESS

1348 Calhoun Street



C14572 00812

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 00812

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Cope land, White

2. DATE AND HOUR OF DEATH

1/17/72

11:05 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF  
HOSPITAL OR  
INSTITUTION(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET  
ADDRESS OR LOCATION)Baltimore City Hospital  
4940 Eastern Avenue, Baltimore, Md. 212244. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  
A. STATE B. COUNTY  
Maryland

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒NO ☐

E. STREET AND NUMBER

2244 Eutaw Place

21217

5. SEX

Male

6. RACE

Negro

7. MARRIED ☐NEVER MARRIED ☐WIDOWED ☒DIVORCED ☐

8. DATE OF BIRTH

2-6-09

9. AGE (In years  
last birthday)

62

10. Under 1 Yr.  
Months: Days:If Under 24 Hrs.  
Hours: Min.10A. USUAL OCCUPATION (Give kind of work  
done during most of working life, even if retired)

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

Nealy

14. MOTHER'S MAIDEN NAME

Ell

15. Was Deceased Ever in U. S. Armed Forces?  
(Yes, no or unknown) (If yes, give war or dates of service)16. SOCIAL  
SECURITY NO.

17. INFORMANT

ADDRESS

BCH-RECORDS

4940 Eastern Avenue  
Baltimore, Maryland

18. 412.31

CAUSE OF DEATH

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHDISEASE OR CONDITION DIRECTLY  
LEADING TO DEATH(This does not mean the mode of dying, e.g.,  
heart failure, asphyxia, etc. It means the disease,  
injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving  
rise to the above cause (A) stating the  
UNDERLYING CONDITION last.(A) IMMEDIATE CAUSE  
DUE TO, OR AS A CONSEQUENCE OF:

Cardiac Arrest

20 min.

(B) DUE TO, OR AS A CONSEQUENCE OF:

Coronary Artery Disease

10 yrs

(C)

Hypertension

10 yrs

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING  
TO THE DEATH BUT NOT RELATED TO THE TERMINAL  
DISEASE OR CONDITION GIVEN IN PART I (A).

COPD

15 yrs

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION  
WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED  
IN CERTIFYING CAUSES OF DEATH?21A. ACCIDENT WAS UNDERLYING  
OR CONTRIBUTING CAUSE OF  
DEATH (Notify medical examiner)21B. PLACE OF INJURY (e.g., in or about  
home, farm, factory, street, office bldg,  
etc.)21C. WHERE DID  
INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME  
OF INJURY  
(APPROX.)

(Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At  
Work ☐Not While  
At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from 1-12 19 72 to 1-17- 1972  
that (I) (we) last saw the deceased alive on 1-17- 19 72 and that in (my) (our) opinion death occurred on the date  
and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

James N. Ingle MD

DEGREE

Attending  
Phys. ☐Med.  
Director ☐Staff  
Phys. ☒

23B. DATE SIGNED

1/17/72

23C. PHYSICIAN'S  
NAME (Type)

James N. Ingle

23D. ADDRESS

4940 Eastern Avenue, Baltimore, Md.

DEGREE

Baltimore City Hospital

24A. BURIAL CREMATION,  
REMOVAL (Specify)

24B. DATE

24C. NAME of CEMETERY or CREMATORY

24D. LOCATION

(City, town, or county)

(State)

25A. DATE REC'D BY HEALTH DEPT.

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

BURIAL 1/22/72

MOUNT AUBURN

BALTO.

MD.

JAN 25 1972

2000 2000

2000 2000

1827 W. NORTH

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

SIAM 9.

SIAM 9.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				CERTIFICATE OF DEATH		REG. NO. <u>72 00813</u>	
BIRTH NO. <u>M 6272 00813</u>				1. NAME OF DECEASED (Type or Print) <u>BEULAH MORGAN</u>		2. DATE AND HOUR OF DEATH <u>1/13/72</u> <u>4:15 P.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>PROVIDENT HOSPITAL</u>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>2841</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F</u> 6. RACE <u>N</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				8. DATE OF BIRTH <u>1-5-15</u> 9. AGE (In years last birthday) <u>57</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>UNEMPLOYED</u>	
11. BIRTHPLACE (State or foreign country) <u>BALTIMORE, MARYLAND</u>				12. CITIZEN OF WHAT COUNTRY? <u>CELESTINE WALLACE</u>		13. FATHER'S NAME <u>RODEN RICHARDSON</u>	
14. MOTHER'S MAIDEN NAME <u>CELESTINE WALLACE</u>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>ill yes, give war or dates of service</u>		16. SOCIAL SECURITY NO. <u>911-18-7018</u>	
17. INFORMANT <u>JEFF RICHARDSON</u>				ADDRESS <u>4322 ELDERON AVE</u>		18. <u>250.9 I</u> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>CONGESTIVE HEART FAILURE</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>		19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>DIABETES MELLITUS</u>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION <u>0</u>				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that <u>N</u> (this hospital) attended the deceased from <u>JAN 12</u> 19 <u>72</u> to <u>JAN 13</u> 19 <u>72</u> that <u>N</u> (we) last saw the deceased alive on <u>JAN 13</u> 19 <u>72</u> and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>N</u> (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>Rayman I. Alley M.D.</u>				23B. DATE SIGNED <u>1/13/72</u>		23C. PHYSICIAN'S NAME (Type) <u>RAYMAN I. ALLEY M.D.</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>1/18/72</u>				24B. DATE <u>1/18/72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>FAMILY PLOT, WELDON, N.C.</u>	
24D. LOCATION (City, town, or county) <u>WELDON, N.C.</u>				24E. STATE <u>N.C.</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1972</u>	
25B. NAME OF REGISTRAR <u>Barbara J. ...</u>				25C. FUNERAL DIRECTOR <u>Earl Gilman</u>		ADDRESS <u>1827 W. NORTH AVE</u>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Baltimore City Health Department				REG. NO. 72 00814	
BIRTH NO. 72 00814		1. NAME OF DECEASED (Type or Print) Oscar W. Hortop		2. DATE AND HOUR OF DEATH Jan. 24, 1972 4:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE B. COUNTY Maryland 2711		
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 5102 Whiteford Ave.			C. CITY OR TOWN Balto.		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER 5102 Whiteford Ave. 21212		
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 7-23-1883	9. AGE (In years last birthday) 88	10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret'd. Accountant		10B. KIND OF BUSINESS OR INDUSTRY Md. Casualty Co.	11. BIRTHPLACE (State or foreign country) Ontario, Canada		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William Hortop			14. MOTHER'S MAIDEN NAME Jane Youart		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes WWI		16. SOCIAL SECURITY NO. 212-10-3569A	17. INFORMANT Mrs. Doris E. Hortop		ADDRESS Same
18. 41221 DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH ASCVD with Hypertension + Chronic Heart Failure (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 13 1/2 yrs.
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (the hospital) attended the deceased from Aug. 29 1956 to Jan. 24 1972, that (I) (we) last saw the deceased alive on 26 Oct 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
23A. SIGNATURE Com. H. Kammer, Jr.			23B. DATE SIGNED 25 Jan. 72		
23C. PHYSICIAN'S NAME (Type) Dr. William H. Kammer, Jr.			23D. ADDRESS 6011 York Road		
24A. BURIAL CREMATION, REMOVAL (Specify) Cremation		24B. DATE 1-25-72		24C. NAME OF CEMETERY or CREMATORY Greenmount	
24D. LOCATION (City, town, or county) Balto.,		(State) Md.			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1972		25B. NAME OF REGISTRAR Robert E. Taylor, Jr.		25C. FUNERAL DIRECTOR H. W. Jenkins & Sons Co. 4905 York Road Balto., Md. 21212	

H26AD work H26AD work  
H26AD work H26AD work

20 Jan 24

21 Jan 24

22 Jan 24

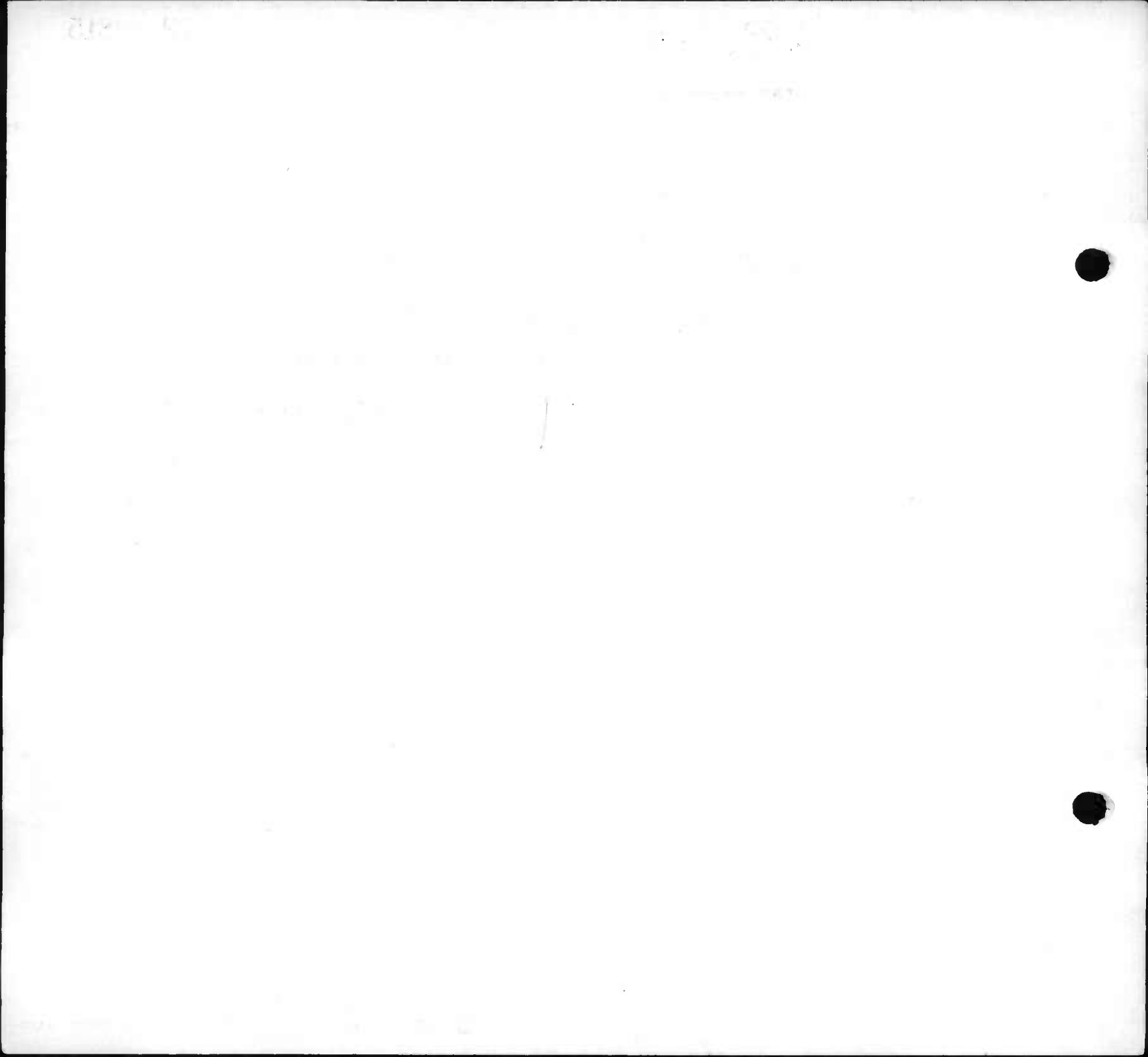
23 Jan 24

24 Jan 24

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

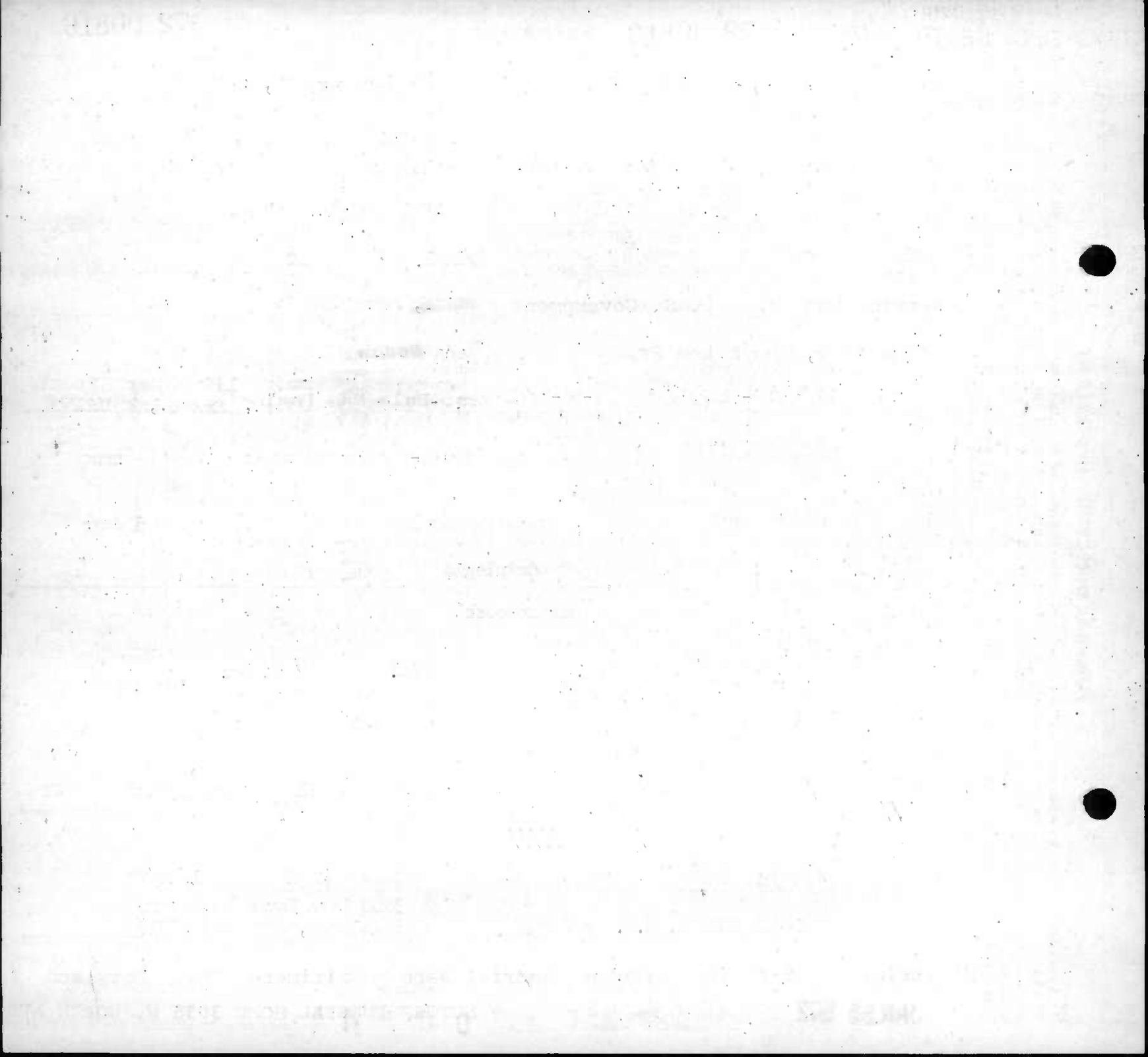
H-616		72 00815		BALTIMORE CITY HEALTH DEPARTMENT		72 00815	
CERTIFICATE OF DEATH				REG. NO.			
1. NAME OF DECEASED (Type or Print) <b>WILLIAM HENRY HERBERT</b>				2. DATE AND HOUR OF DEATH <b>1-20-72</b> <b>8:58 P.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SINAI HOSPITAL OF BALTIMORE, INC.</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>2714</b>			
				C. CITY OR TOWN <b>Baltimore</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
				E. STREET AND NUMBER <b>4673 FALLS ROAD</b>			
5. SEX <b>MALE</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3-1-08</b>	9. AGE (In years last birthday) <b>63</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>chauffeur</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>Deeley Dental Supply Company</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Joseph Herbert</b>				14. MOTHER'S MAIDEN NAME <b>Willie Ann Young</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-07-3304</b>		17. INFORMANT ADDRESS <b>Mrs. Gwendolyn Herbert 4673 Falls Road</b>			
18. CAUSE OF DEATH <b>582X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>UREMIA (CHRONIC RENAL FAILURE)</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>HIGH BLOOD PRESSURE</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-24</b> 19 <b>71</b> to <b>1-20</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1-20</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Susan Macht Foken MD</b>				23B. DATE SIGNED <b>1-20-72</b>		Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-25-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>New Cathedral Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Beck 207-3000</b>		25C. FUNERAL DIRECTOR ADDRESS <b>NOTTER FUNERAL HOME 3035 W. NORTH AVE.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 00816		CERTIFICATE OF DEATH		72 00816	
BIRTH NO. <span style="font-size: 2em;">7-460</span> 1. NAME OF DECEASED (Type or Print) <b>FOWLER, JOSEPH LEE JR.</b>				2. DATE AND HOUR OF DEATH <b>January 22, 1972</b> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 2em;">23</span> <b>Veterans Administration Hospital</b> <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>Baltimore</b> C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1722 Division Street</b>			
5. SEX <b>Male</b>		6. RACE <b>Negro</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>9/11/29</b>	
9. AGE (In years last birthday) <b>42</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Service Man</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>U. S. Government</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>FOWLER, Joseph Lee Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Rena Roach</b>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <b>12/10/52- 10/31/53</b>	
16. SOCIAL SECURITY NO. <b>212-26-3873</b>		17. INFORMANT <b>Mrs. Eula Mae Fowler, Emporia, Va.</b>		ADDRESS <b>112 Baker Street</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
18. <b>796.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>Cardio-respiratory arrest</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pulmonary embolus</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Quadruplegia</b> (C) <b>Hip abscess</b>				ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Hip abscess</b>			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR?		(If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?		22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>November 1st</b> 19 <b>71</b> to <b>January 22nd</b> 19 <b>72</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>January 22nd</b> 19 <b>72</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death.	
23A. SIGNATURE				23B. DATE SIGNED <b>1/24/72</b>		23C. PHYSICIAN'S NAME (Type) <b>DAVID POSNER, M.D.</b>	
23D. ADDRESS <b>3900 Loch Raven Boulevard</b> <b>Baltimore, Maryland 21218</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-27-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Arbutus Memorial Park</b>	
24D. LOCATION (City, town, or county) <b>Baltimore Co.,</b>		24E. STATE (State) <b>Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>	
25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME</b>		ADDRESS <b>3035 W. NORTH AVE</b>		25D. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25E. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-423 72 00817		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		72 00817	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>Sorothy Blackston</u>		2. DATE AND HOUR OF DEATH <u>1/23/1972</u> <u>12:40 p.m.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1608</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>Lutheran Hospital of Md, Inc</u> <u>730 Ashborton Street</u>		C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>FEMALE</u>		6. RACE <u>NEGRO</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stock Control Clerk</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Post Engineer</u> <u>Ft. Meade</u>		8. DATE OF BIRTH <u>12-10-26</u>	
13. FATHER'S NAME <u>JOHN RICHARD WOOLFORD</u>		14. MOTHER'S MAIDEN NAME <u>GERTRUDE WASHINGTON</u>		9. AGE (In years last birthday) <u>45</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>220-24-0426</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
		17. INFORMANT <u>Mr. Clarence H. Blackston</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
18. <u>427.0</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Uraemia</u> <u>Chronic Renal failure</u>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive Heart failure</u>			
		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>failure</u>			
		(C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20A. AUTOPSY? (Yes or No) <u>no</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) _____		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR? _____	
22. I certify that (I) (this hospital) attended the deceased from <u>Jan 19</u> 19 <u>72</u> to <u>Jan 23</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Jan 23</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.					
23A. SIGNATURE <u>D.S. Karbhari</u>		23B. DATE SIGNED <u>1/23/72</u>		23C. PHYSICIAN'S NAME (Type) <u>D-S. KARBHARI</u>	
23D. ADDRESS <u>Lutheran Hospital</u> <u>Balto MD 21216</u>		23E. FUNERAL DIRECTOR <u>NUTTER FUNERAL HOME 3035 W. NORTH AVE.</u>			
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-27-72</u>		24C. NAME of CEMETERY or CREMATORY <u>Arbutus Memorial Park</u>	
24D. LOCATION <u>Baltimore Co., Maryland</u>		25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1972</u>			
25B. NAME OF REGISTRAR <u>Robert E. Taylor</u>		25C. NAME OF REGISTRAR <u>72 00817</u>			

15-10817

15-10817

15-10817

15-10817

15-10817

15-10817

15-10817

15-10817

15-10817

15-10817



1

*M-254* 72 00818 BALTIMORE CITY HEALTH DEPARTMENT  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 72 00818

1. NAME OF DECEASED (Type or Print) <b>Myra McNeal</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month <b>1</b> Day <b>21</b> Year <b>72</b> Estimated <input type="checkbox"/>		3. DATE PRONOUNCED DEAD Month <b>1</b> Day <b>21</b> Year <b>72</b> Hour <b>10:40</b> P.M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1512 Montmore Court.</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1501</b>			
6. SEX <b>female</b>	7. RACE <b>Negro</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>1-18-1892</b>		10. AGE (In years last birthday) <b>80</b>	11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>? ?</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		15. MOTHER'S MAIDEN NAME <b>? Bagley</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>215-50-7769</b>		18. INFORMANT <b>Mr. James W. Tanner</b>	
19. <b>412.4</b>		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>no</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		22F. HOW DID INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> DATE SIGNED <b>1/22/72</b> EXAMINER'S NAME (Type)					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-28-1972</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Auburn Cemetery</b>	
24D. LOCATION (City, town, or county) <b>Baltimore</b>		24E. LOCATION (City, town, or county) <b>Maryland</b>			
25A. DATE REC'D BY HEALTH DEPT <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>		25C. FUNERAL DIRECTOR <b>NUTTER FUNERAL HOME</b>	
25D. ADDRESS <b>3035 W. NORTH AV</b>					

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

12-15-1961

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

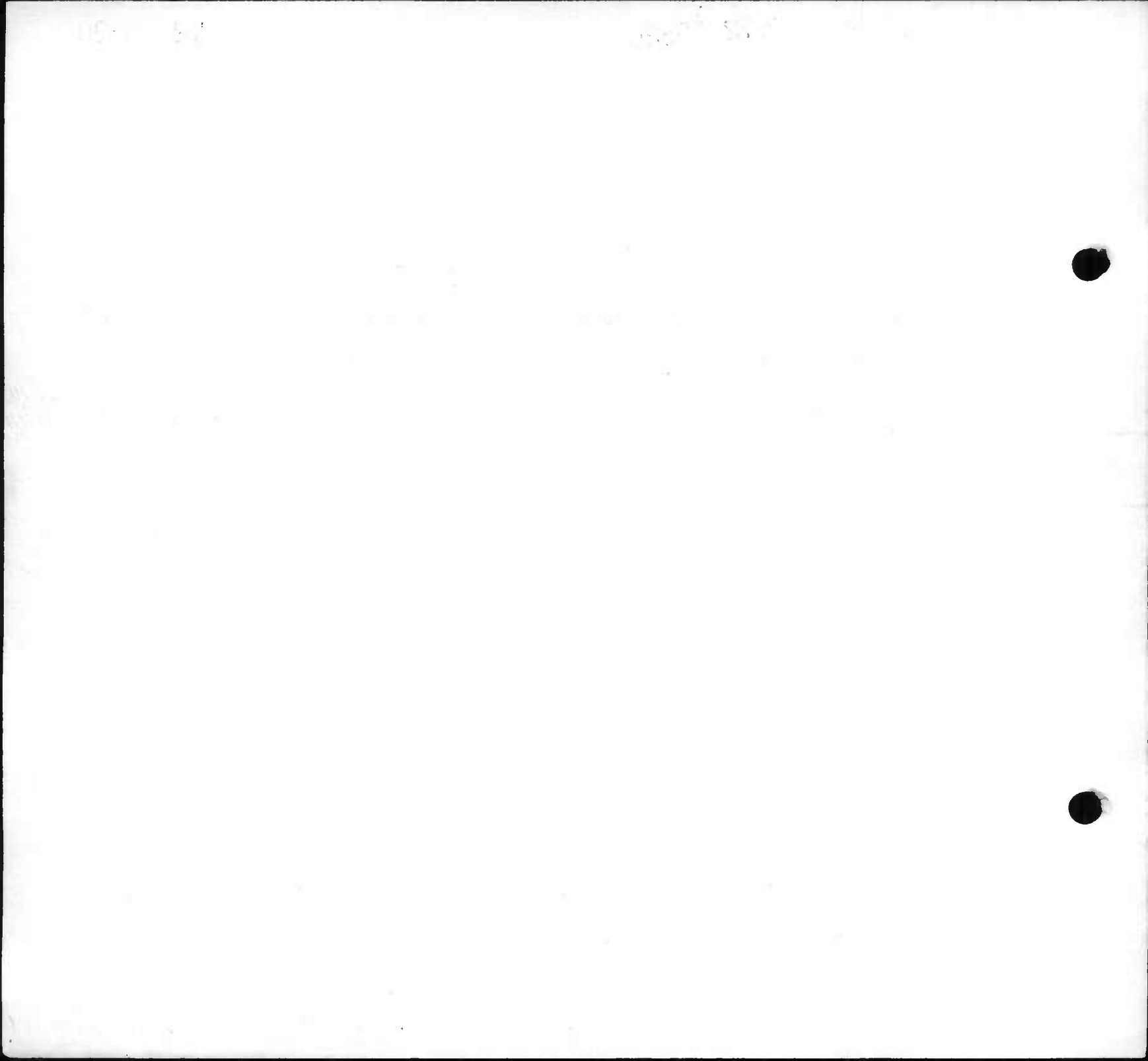
<div style="display: flex; justify-content: space-between;"> <span>M-200</span> <span>72 00819</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>72 00819</span> <span>CERTIFICATE OF DEATH</span> </div>		<div style="display: flex; justify-content: space-between;"> <span>REG. NO.</span> <span>72 00819</span> </div>	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		GERTRUDE E. MOXEY		1. 23. 72 110. 20 A M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE B. COUNTY			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
CHURCH HOME & HOSPITAL 35		TOWN			
		E. STREET AND NUMBER			
		1706 RAMBLEWOOD RD.			
5. SEX	6. RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months Days
F	W	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. 1. 1883.	88	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
COMPANION WORKER.				N. J.	
12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
U.S.A.		FRANK MOXEY		SARAH WARREN.	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO		219 308543		HOSPITAL CHART.	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
412.41					
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		Unknown.	
ANTECEDENT CAUSES		(B) ASCVD, CHF		Unknown	
		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from 12. 16. 71 1971 to 1. 23. 1972, that (I) (we) last saw the deceased alive on 1. 23. 1972 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE		23B. DATE SIGNED			
Sagall Jr.		1. 23. 72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY	
Burial		Jan. 25, 1972		Pineville Ridge Cemetery	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 25 1972		26. 08 30. 7. 72		Pineville Ridge Cemetery, Md.	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

V-200		72 00820		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		72 00820		
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>John J. Veise</u>				2. DATE AND HOUR OF DEATH <u>1/19/72</u> <u>12:45A</u> M.				
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD						4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>PRATO</u> <u>5300</u>				
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>Maryland General Hospital</u>						C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
E. STREET AND NUMBER <u>17 clarendon Ave</u>										
5. SEX <u>Male</u>	6. RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>8/3/15</u>		9. AGE (In years last birthday) <u>56</u>		If Under 1 Yr. Months: Days: Hours: Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Technician</u>				10B. KIND OF BUSINESS OR INDUSTRY <u>John Hopkins Univ.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>WILLIAM F. VEISE</u>				14. MOTHER'S MAIDEN NAME <u>MAYFIELD WEIDERMAN</u>						
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W. W. II</u>				16. SOCIAL SECURITY NO. <u>212-037174</u>		17. INFORMANT <u>MRS. WILKIE FRANCES VEISE</u>				
18. <u>53201</u>				CAUSE OF DEATH				ADDRESS <u>PIKEVILLE 8, MD.</u>		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>massive gastro-intestinal bleeding</u>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>duodenal ulcer (peptic type)</u>				(B) DUE TO, OR AS A CONSEQUENCE OF:						
(C)										
II										
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).										
19A. DATE OF OPERATION <u>1/19/72</u>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)			21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>			21F. HOW DID INJURY OCCUR?				
22. I certify that (I) (this hospital) attended the deceased from <u>12/20</u> 19 <u>71</u> to <u>1/19</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/19</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.										
23A. SIGNATURE <u>Michael A. Silverman MD</u>						Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <u>1/19/72</u>		
23C. PHYSICIAN'S NAME (Type) <u>Michael A. Silverman MD</u>						23D. ADDRESS <u>Maryland General Hospital</u>				
24A. BURIAL, CREMATION, REMOVAL (Specify)			24B. DATE <u>Jan. 22, 1972</u>			24C. NAME OF CEMETERY or CREMATORY <u>Wood Ridge Cemetery</u>			24D. LOCATION (City, town, or county) (State) <u>Pikesville, Balto., Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1972</u>			25B. NAME OF REGISTRAR <u>Robert E. Taylor, R.D.O.</u>			25C. FUNERAL DIRECTOR <u>Burial 90</u>			ADDRESS <u>Pikesville 8, Md.</u>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00821	
CERTIFICATE OF DEATH				REG. NO. 72 00821	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH			
JOAN MARY WILKINS		01-23-72 1:45 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		A. STATE		B. COUNTY	
33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205		MARYLAND		BALTIMORE	
		C. CITY OR TOWN		D. INSIDE CITY LIMITS?	
		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER			
		1319 DARTMOUTH AVE			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. If Under 1 Yr. Months Days
FEMALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	04-15-36	35	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
R.N.				Md.	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME		12. CITIZEN OF WHAT COUNTRY?	
MARTIN STROZYKOWSKI		Irene Slowakiewicz		USA	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT	
yes 58-60		216-34-4910		Richard W. Wilkins same	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		4 days	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF:			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY (Yes or No)	
1/20/72		acoustic neuroma		NO	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
No		8		8	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At <input checked="" type="checkbox"/> Work At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
				8	
22. I certify that (I) (this hospital) attended the deceased from 1/20 19 72 to 1/23 19 72 and that (I) (we) last saw the deceased alive on 1/23 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE				23B. DATE SIGNED	
Frederick H. Selar MD				1/23/72	
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS	
FREDERICK H. SELAR MD				JOHNS HOPKINS HOSPITAL, BALTIMORE, MD.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY OR CREMATORY	
Burial		1/27/72		Holy Rosary	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR	
JAN 25 1972		V. J. E. [Signature]		Leonard J. Ruck Inc. Balto. Md.	

152005

152005

152005

152005

152005

152005

152005

152005



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

Y-250 72 00822				BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00822	
1. NAME OF DECEASED (Type or Print) <u>Beatrice H. Vazzana</u>				2. DATE AND HOUR OF DEATH <u>1/22/72</u> <u>3 A.</u> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>00 3206 Rueckert Ave.</u>				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2743</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <u>3206 Rueckert Ave.</u>			
5. SEX <u>F.</u>	6. RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/18/1900</u>		9. AGE (In years last birthday) <u>71</u>	10. If Under 1 Yr. Months: Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>John Mullen</u>				14. MOTHER'S MAIDEN NAME <u>Mary Byrd</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u>			16. SOCIAL SECURITY NO. <u>218-14-0129A</u>		17. INFORMANT <u>Mrs. Beatrice Zabkowski same</u>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.) <u>151.91 Metastatic Carcinoma of Stomach</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>II</u> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Metastatic Carcinoma of Stomach</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>of Stomach</u> (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 months</u>	
MEDICAL CERTIFICATION							
19A. DATE OF OPERATION <u>01/10/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Cancer of Stomach</u>		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>1/5</u> 19 <u>50</u> to <u>1/22</u> 19 <u>72</u> , that (I) (we) last saw the deceased alive on <u>1/21/72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>		23B. DATE SIGNED <u>1/22/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Israel S. Zinberg MD.</u>				23D. ADDRESS <u>4000 W. Northern Parkway Balto. Md.</u>			
24A. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/25/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>New Cathedral</u>		24D. LOCATION (City, town, or county) (State) <u>Balto. Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc.</u>		ADDRESS <u>Balto. Md.</u>	

10/11/72

10/11/72

10/11/72

10/11/72

10/11/72

10/11/72

10/11/72

10/11/72

10/11/72

10/11/72

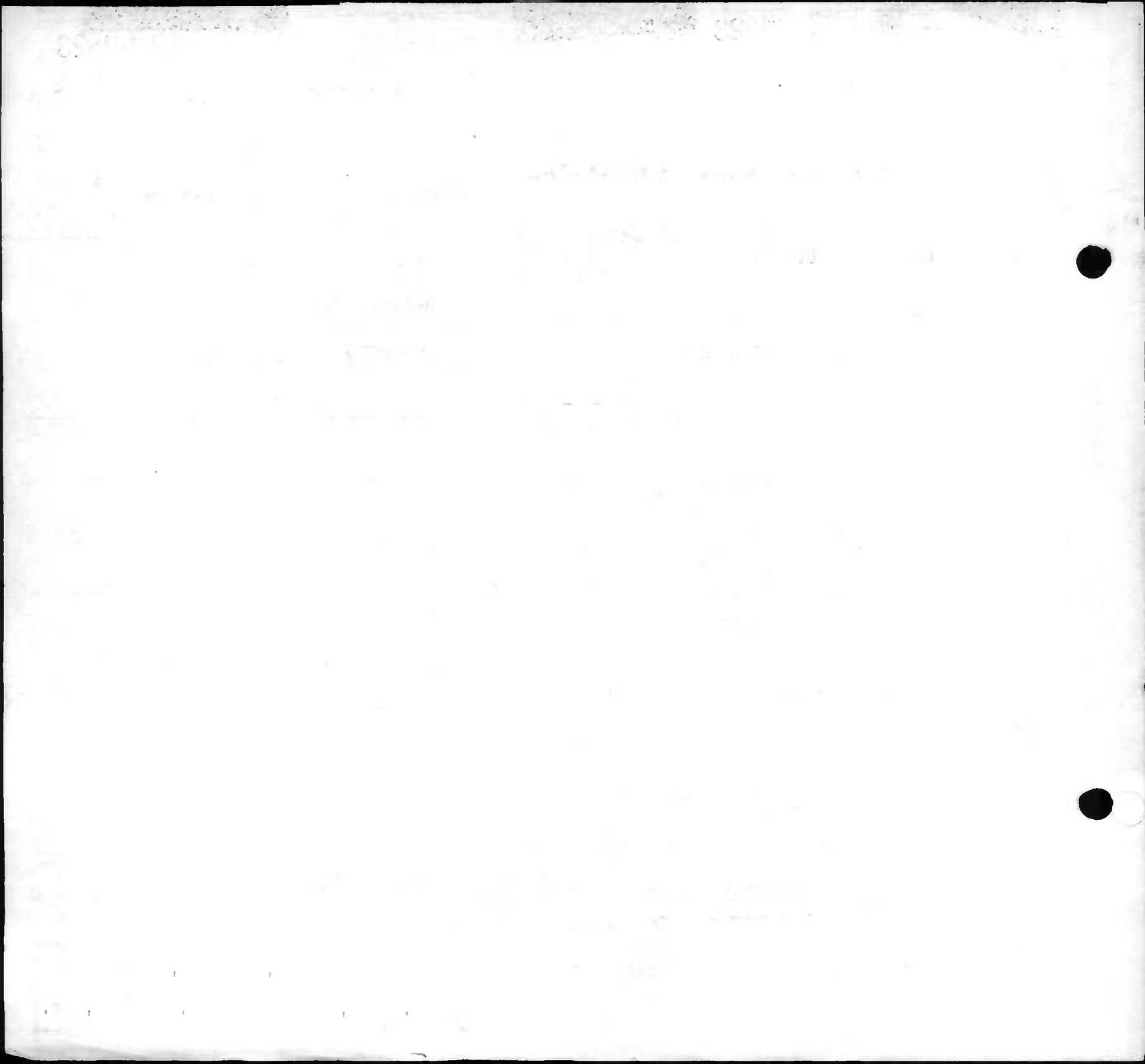
10/11/72

10/11/72

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00823</b>	
BIRTH NO. <b>R-22072 00823</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>NOLA M. RUZEK</b>		2. DATE AND HOUR OF DEATH <b>1-20-72</b> <b>6 08</b> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>MD</b> <b>Baltimore</b>	
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>35 CHURCH HOME &amp; HOSPITAL</b> <b>Church Home &amp; Hospital</b>		C. CITY OR TOWN <b>Dundalk</b>	D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
		E. STREET AND NUMBER <b>3701 North Point Road</b> <b>3701 N. Point Road</b> <b>21222</b>	
5. SEX <b>Female</b>	6. RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-20-09</b> <b>62</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hairdresser</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>62</b>
11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>RUFUS HILTON</b>		14. MOTHER'S MAIDEN NAME <b>MINTA WHITNER</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>238-12-5806</b>	17. INFORMANT <b>FREDERICO TAN</b>
		ADDRESS <b>CHURCH HOME AND HOSPITAL</b>	
18. <b>198.31</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Ca to Brain. Rt Hemiplegia 4 days.</b>		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Brain. Rt Hemiplegia 4 days.</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Rt Middle Lobe pneumonia</b>		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>2 Aphasia - ? Hemorrhage to brain.</b>	
		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>1/14/72</b>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY (Yes or No) <b>Yes</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notly medical examined)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-14-72</b> to <b>1-20-72</b> that (I) (we) last saw the deceased alive on <b>1-19-72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Federico Tan</b>			23B. DATE SIGNED <b>Jan 20/72</b>
23C. PHYSICIAN'S NAME (Type) <b>Federico Tan</b>			23D. ADDRESS <b>CHURCH HOME &amp; HOSPITAL</b>
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>	24B. DATE <b>1/24/72</b>	24C. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel Church Cemetery</b>	24D. LOCATION (City, town, or county) (State) <b>Hickory, Catawba, North Carolina</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>John J. Jada</b>	25C. FUNERAL DIRECTOR <b>John J. Jada</b>
		ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>	



## FUNERAL DIRECTOR: IMPORTANT

DR. KORNBLUM OF THE MEDICAL EXAMINER'S OFFICE  
This certificate must be approved by the Chief Medical Examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

C-62172-00518		72 00824		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00824	
BIRTH NO. 72-00518				1. NAME OF DECEASED S. AARON CRISP			
2. DATE AND HOUR OF DEATH 7:30 PM JAN 21, 1972				3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			
4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE				5. SEX MALE 6. RACE WHITE 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
6. CITY OR TOWN Dundalk 7. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				8. DATE OF BIRTH 01-08-72 9. AGE (In years last birthday) 13			
E. STREET AND NUMBER 8239 BULL NECK ROAD				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Dependent			
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME DONALD CRISP				14. MOTHER'S MAIDEN NAME MICHELLE GRAMMER			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) No				16. SOCIAL SECURITY NO.			
17. INFORMANT Father: Mr. Donald L. Crisp				ADDRESS 8239 Bullneck Road Dundalk, Md. 21222			
18. 03871 CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH				20. IMMEDIATE CAUSE CARDIO-RESPIRATORY ARREST 20 minutes			
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)				DUE TO, OR AS A CONSEQUENCE OF: Hypotensive - septic shock 60 minutes			
ANTECEDENT CAUSES				(b) DUE TO, OR AS A CONSEQUENCE OF: OVERWHELMING SEPSIS 18 Hours			
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(c) Possible Congenital Heart disease			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION 2				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20A. AUTOPSY? (Yes or No) Yes				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)							
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
21F. HOW DID INJURY OCCUR?							
22. I certify that (I) (this hospital) attended the deceased from JANUARY 21 7:30 PM 1972 to 7:30 PM JAN 21 1972 that (I) (we) last saw the deceased alive on 7:30 PM JAN 21 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Alan Cooper Smith M.D.				23B. DATE SIGNED JAN 21 1972			
23C. PHYSICIAN'S NAME (Type) COOPER Smith M.D.				23D. ADDRESS THE JOHNS HOPKINS HOSPITAL			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1-25-72			
24C. NAME OF CEMETERY or CREMATORY Holly Hill Memorial Gardens				24D. LOCATION (City, town, or county) (State) White Marsh, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1972				25B. NAME OF REGISTRAR John O. Duda			
25C. FUNERAL DIRECTOR ADDRESS 9922 Wise Ave. Dundalk, Md. 21222							



60-48-48 1 jr

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

I-252		72 00825		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00825	
BIRTH NO.				CERTIFICATE OF DEATH			
1. NAME OF DECEASED (Type or Print) Albert A. Isennock, Sr. ALBERT ISENNOCK				2. DATE AND HOUR OF DEATH 1/20/72 10:1 PM			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE Maryland B. COUNTY 2605			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
E. STREET AND NUMBER 6804 Fait Avenue 21224							
5. SEX Male	6. RACE Caucasian	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9/28/98	9. AGE (In years last birthday) 73	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired		10B. KIND OF BUSINESS OR INDUSTRY Beth. Steel Co.		11. BIRTH PLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alexander Isennock				14. MOTHER'S MAIDEN NAME Lola McCleary			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 213-07-0547		17. INFORMANT 4940 Eastern Avenue ADDRESS Baltimore, Maryland 21224 BCH: Records			
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. I 185 X I CAUSE OF DEATH Metastatic Prostatic Car (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) Cardiorespiratory Arrest DUE TO, OR AS A CONSEQUENCE OF: (C) Pulmonary embolus APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 yrs 3 days							
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION O		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from 1/18/72 to 1/20/72 that (I) (we) last saw the deceased alive on 1/20/72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE D. Antaglia MD				23B. DATE SIGNED 1/20/72			
23C. PHYSICIAN'S NAME (Type) D. Antaglia MD				23D. ADDRESS Baltimore City Hospitals 4940 Eastern Avenue Baltimore, Maryland 21224			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-24-72		24C. NAME OF CEMETERY or CREMATORY Oak Lawn		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1972		25B. NAME OF REGISTRAR John J. Duda		25C. FUNERAL DIRECTOR John J. Duda		ADDRESS 3922 Wise Ave. Dundalk, Md. 21222	

1500

1500

1500

1500

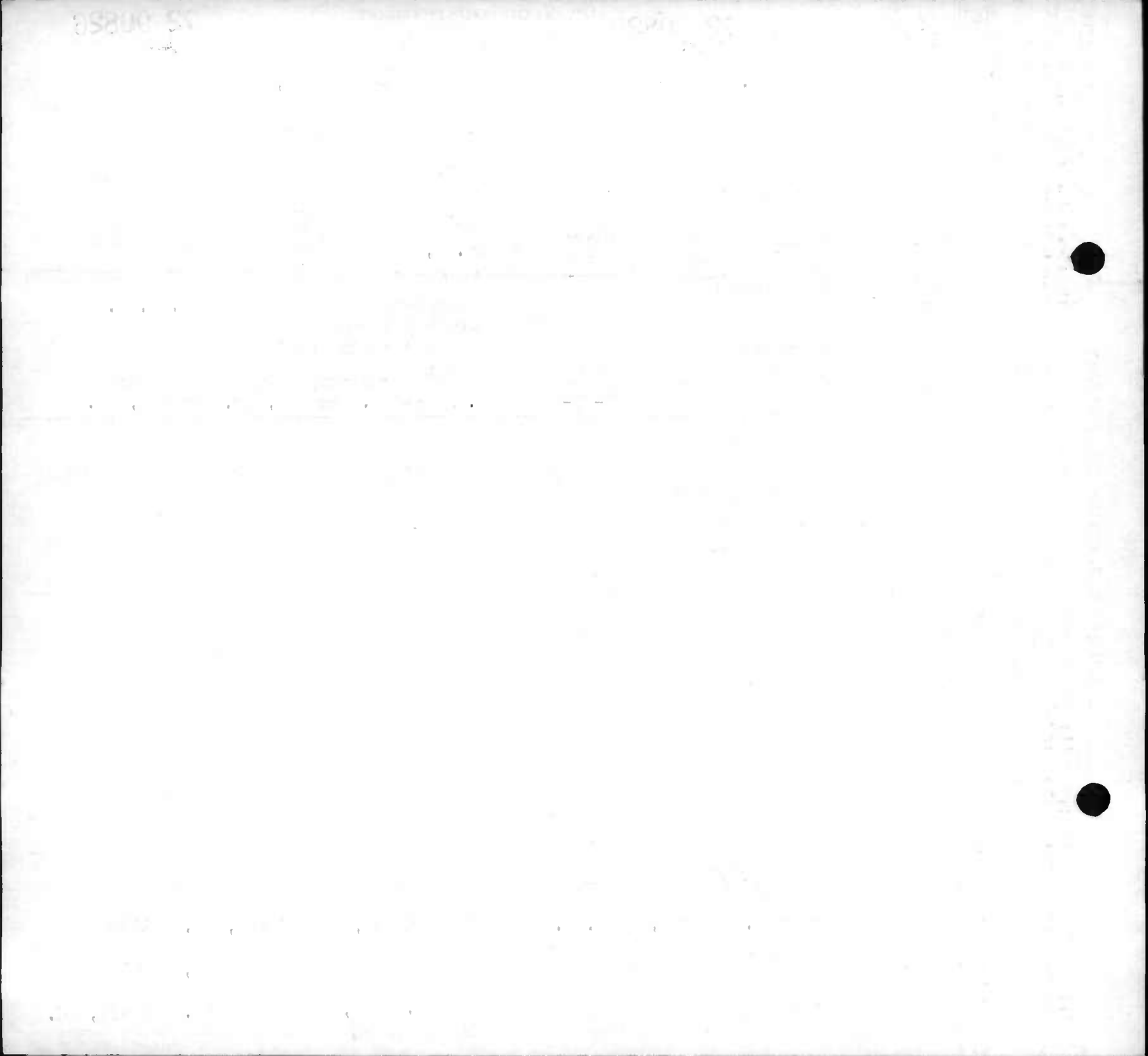
1500



# FUNERAL DIRECTOR: IMPORTANT

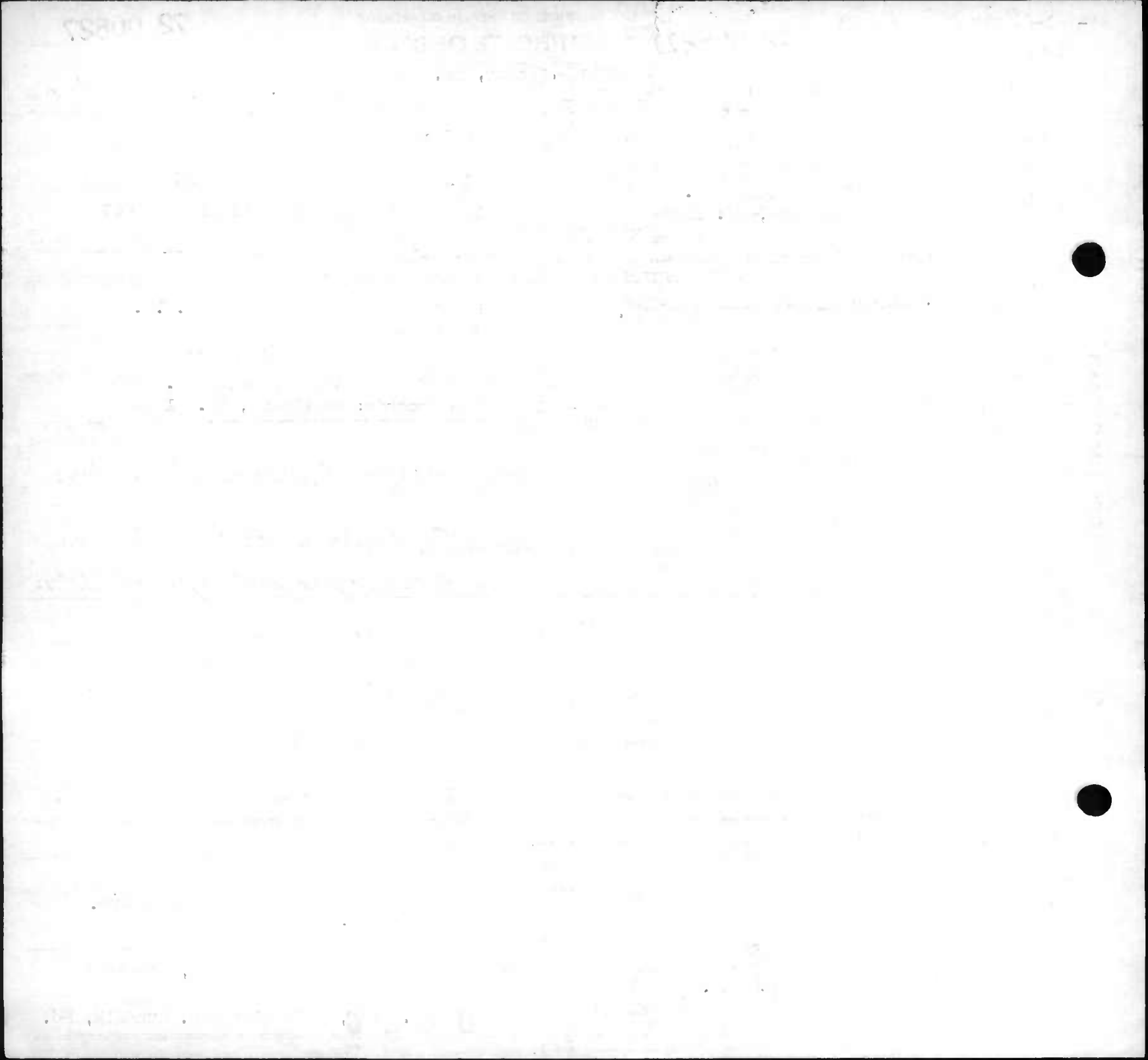
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 00826		72 00826	
BIRTH NO. <span style="font-size: 2em;">2120</span>		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Mabel E. Phoebus</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">January 22, 1972</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <span style="font-size: 1.5em;">31</span> <span style="font-size: 1.2em;">Baltimore City Hospital</span> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> B. COUNTY <span style="font-size: 1.2em;">Baltimore</span> C. CITY OR TOWN <span style="font-size: 1.2em;">Dundalk</span> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <span style="font-size: 1.2em;">2921 Dunmurry Road</span>		
5. SEX <span style="font-size: 1.2em;">Female</span>	6. RACE <span style="font-size: 1.2em;">White</span>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">Nov. 9, 1896</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">75</span>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Housewife</span>			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Maryland</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U. S. A.</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">John Crawford</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">Elizabeth Harris</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">No</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">213-07-9596B</span>			17. INFORMANT (Husband) <span style="font-size: 1.2em;">2921 Dunmurry Road</span> <span style="font-size: 1.2em;">Mr. Edward G. Phoebus, Sr. Dundalk, Md.</span>		
18. <span style="font-size: 1.5em;">470X1</span> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			CAUSE OF DEATH  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <span style="font-size: 1.5em;">Ang Kong Flu</span>  (B) <span style="font-size: 1.5em;">ASCV Dis</span> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">2 days</span>			OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)			
21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1960</span> 19 to <span style="font-size: 1.2em;">1972</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">1/21</span> 19 <span style="font-size: 1.2em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE  <span style="font-size: 1.5em;">Roger G. Windsor,</span>			23B. DATE SIGNED <span style="font-size: 1.2em;">1/24/72</span>		23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">M. D.</span>
23D. ADDRESS <span style="font-size: 1.2em;">520 D Street, Baltimore, Md. 21219</span>			24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>		
24B. DATE <span style="font-size: 1.2em;">1/25/72</span>		24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Meadowridge Memorial Park</span>		24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Dorsey, Maryland</span>	
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.5em;">JAN 25 1972</span>		25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">John J. Duda</span>		25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">7922 Wise Ave. Dundalk, Md.</span>	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

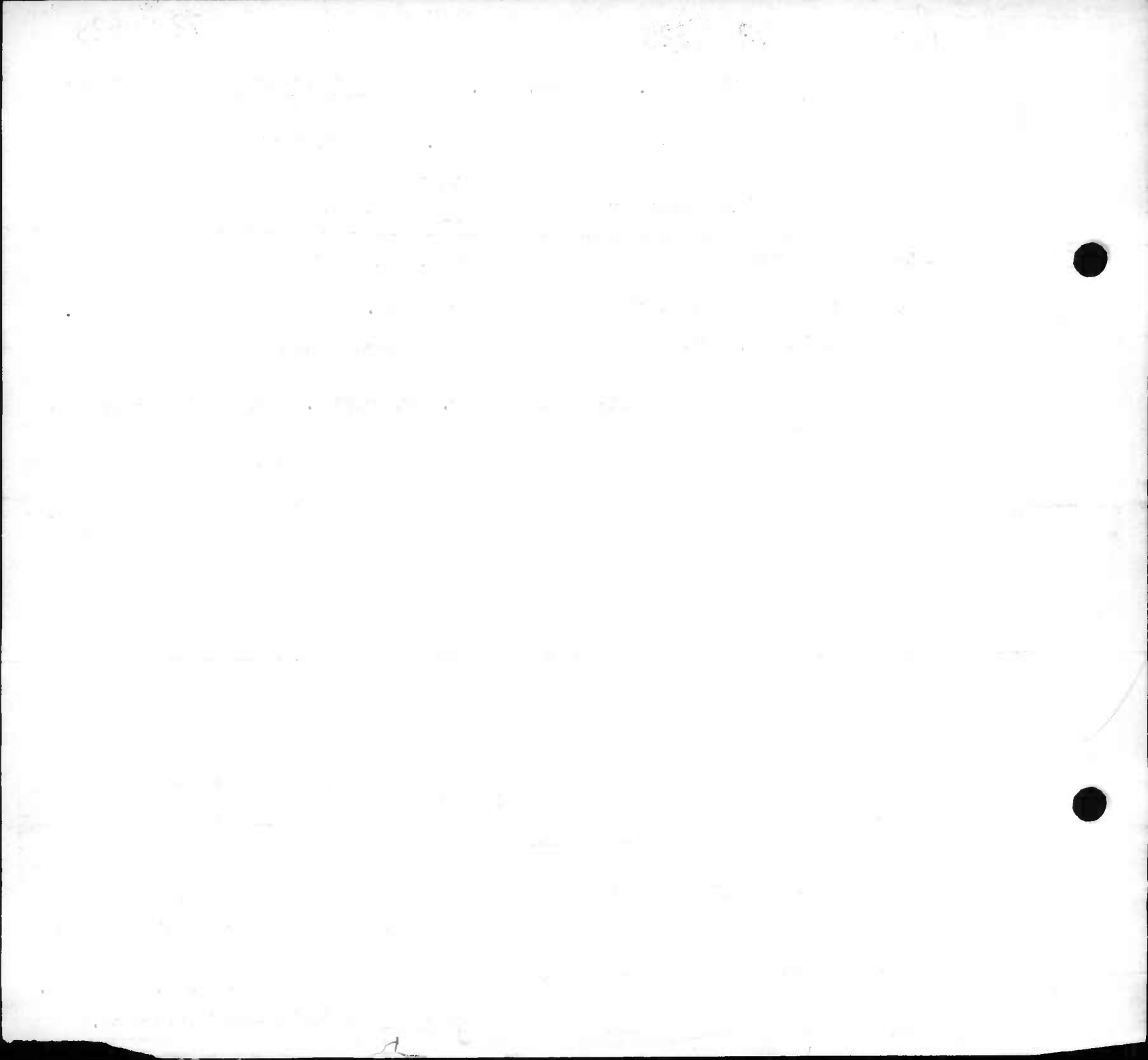
BIRTH NO. <b>B-600</b>		72 00827		BALTIMORE CITY HEALTH DEPARTMENT		72 00827	
1. NAME OF DECEASED (Type or Print) <b>Louis F. Bauer, Sr.</b>				2. DATE AND HOUR OF DEATH <b>Jan. 20, 1972 11:15 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION <b>Baltimore City Hospitals</b> ADDRESS OR LOCATION <b>4940 Eastern Ave.</b> <b>Baltimore, Md. 21224</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2634</b>			
5. SEX <b>Male</b>		6. RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-24-13</b>	
9. AGE (In years last birthday) <b>58</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Electrician-Bethlehem Steel Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Charles Bauer</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Firsterman</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>212-01-9219</b>		17. INFORMANT <b>4940 Eastern Ave.</b> ADDRESS <b>BCH Records: Baltimore, Md. 21224</b>			
18. <b>410.01-250.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Diabetes mellitus, obesity, hypertension</b>				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>bacterial pneumonia</b> (B) <b>cardiogenic shock</b> (C) <b>acute myocardial infarction</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>7 days</b> <b>7 days</b>	
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>Yes</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>Yes</b>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>Jan. 13, 1972</b> to <b>Jan. 20, 1972</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>Jan. 20, 1972</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>J. E. Manitoue, MD</b>				23B. DATE SIGNED <b>Jan. 20, 1972</b>		23C. PHYSICIAN'S NAME (Type) <b>JAY E. MANITOU, MD</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/24/72</b>		24C. NAME of CEMETERY or CREMATORY <b>Meadowridge Memorial Park</b>		24D. LOCATION (City, town, or county) (State) <b>Dorsey, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Vabey, MD</b>		25C. FUNERAL DIRECTOR <b>John J. Dudgeon</b>		ADDRESS <b>7922 Wise Ave. Dundalk, Md.</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

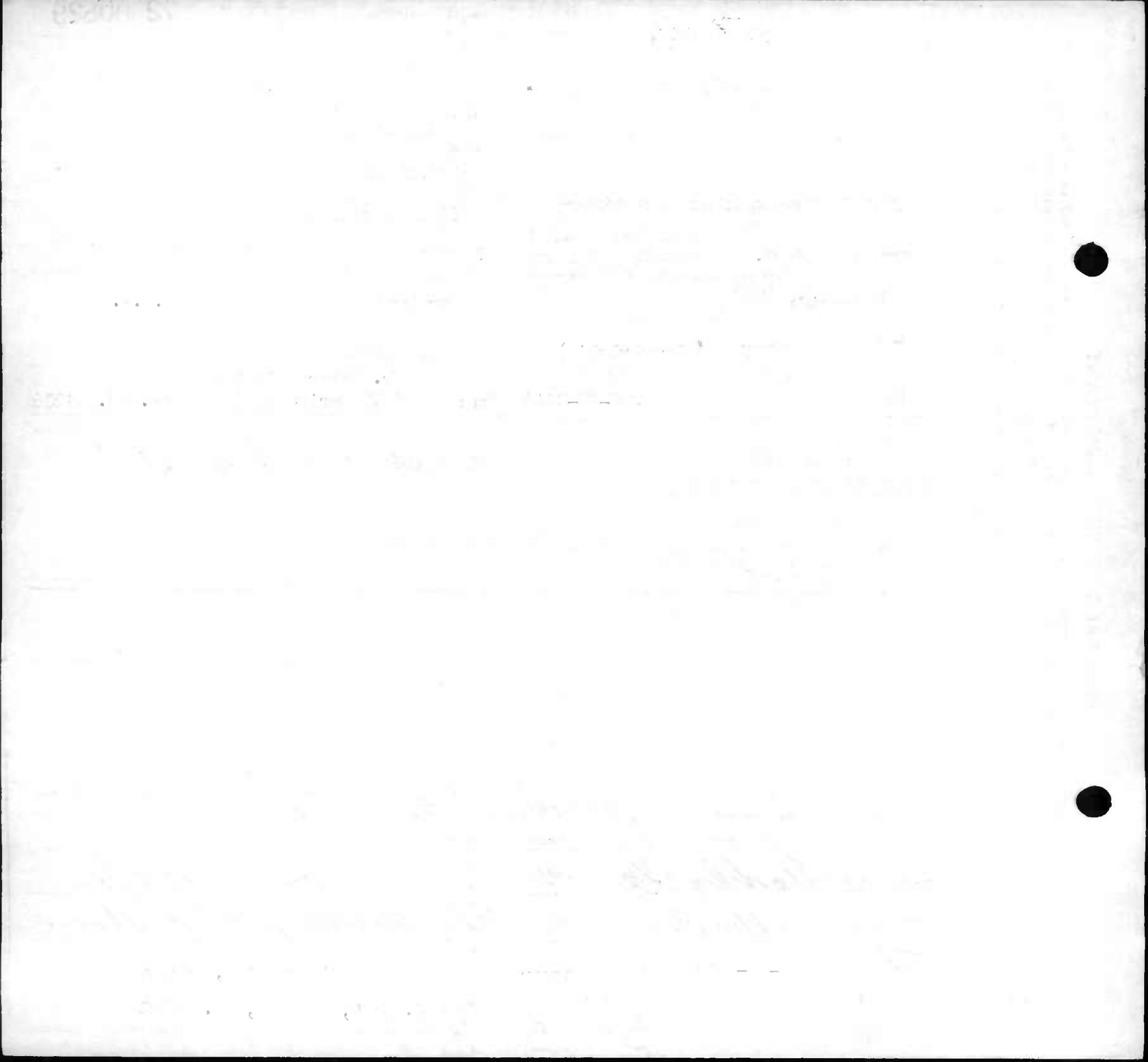
B-635		72 00828		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00828	
1. NAME OF DECEASED (Type or Print) <b>WILBUR D. BURTON, JR.</b>				2. DATE AND HOUR OF DEATH <b>1/18/1972 1:30 P.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>831 PARK AVE</b>				4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>831 PARK AVE</b>			
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 7, 1912</b>	9. AGE (In years last birthday) <b>59</b>	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Dentist</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Dentistry</b>		11. BIRTHPLACE (State or foreign country) <b>Dover Del.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Wilbur D. Burton</b>				14. MOTHER'S MAIDEN NAME <b>Murray Wharton</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>WWII</b>		16. SOCIAL SECURITY NO. <b>213388221</b>		17. INFORMANT <b>Mrs. Katherine I. Burton 831 Park Ave</b>			
18. <b>4/29</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute myocardial infarction</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerotic heart disease</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 Hour</b> <b>Uncertain</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <b>3/26</b> 19 <b>70</b> to <b>1/18</b> 19 <b>72</b> that (I) ( <del>we</del> ) last saw the deceased alive on <b>About 2 months ago</b> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) (did) ( <del>did not</del> ) view the body after death.							
23A. SIGNATURE <b>Gordon Cader M.D.</b>				23B. DATE SIGNED <b>1/19/72</b>			
23C. PHYSICIAN'S NAME (Type) <b>GORDON CADER, M. D.</b>				23D. ADDRESS <b>611 Park Avenue Baltimore, Maryland 21201</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/24/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>National Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Culpepper, Va.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Jones</b>		25C. FUNERAL DIRECTOR <b>Mitchell Wiedefeld Home 6500 York Rd.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-242 72 00829		CITY OF BALTIMORE BIRTH NO. 72 00829		CITY OF BALTIMORE CERTIFICATE OF DEATH		REG. NO. 72 00829	
1. NAME OF DECEASED (Type or Print) NICKLES, Josephine D.				2. DATE AND HOUR OF DEATH 1/20/72 2:25 P.M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 33 The Johns Hopkins Hospital				4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE Maryland B. COUNTY C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER 3119 Shannon Drive			
5. SEX Female	6. RACE Cauc.	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3/4/06	9. AGE (In years last birthday) 65	If Under 1 Yr. Months: Days: Hours: Min.	If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME John Phillips (Przybylski)				14. MOTHER'S MAIDEN NAME MICHALINA Jaworski			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 220-50-2546		17. INFORMANT Mr. Robert Nickles Son: 5227 Darion Road Balto. Md. 21206		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) 174 X I CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Ca of Breast (B) DUE TO, OR AS A CONSEQUENCE OF: (C) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) No		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from January 2 1972 to January 20 1972 that (I) (we) last saw the deceased alive on January 20 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE James Franklin Grim MD				23B. DATE SIGNED 1/20/72		23C. PHYSICIAN'S NAME (Type) James Franklin Grim MD	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1-24-1971		24C. NAME OF CEMETERY OR CREMATORY Holy Redeemer	
24D. LOCATION (City, town, or county) (State) Baltimore City, Maryland				25A. DATE REC'D BY HEALTH DEPT. JAN 25 1972			
25B. NAME OF REGISTRAR John J. Duda				25C. FUNERAL DIRECTOR ADDRESS Dundalk, Md. 21222			





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

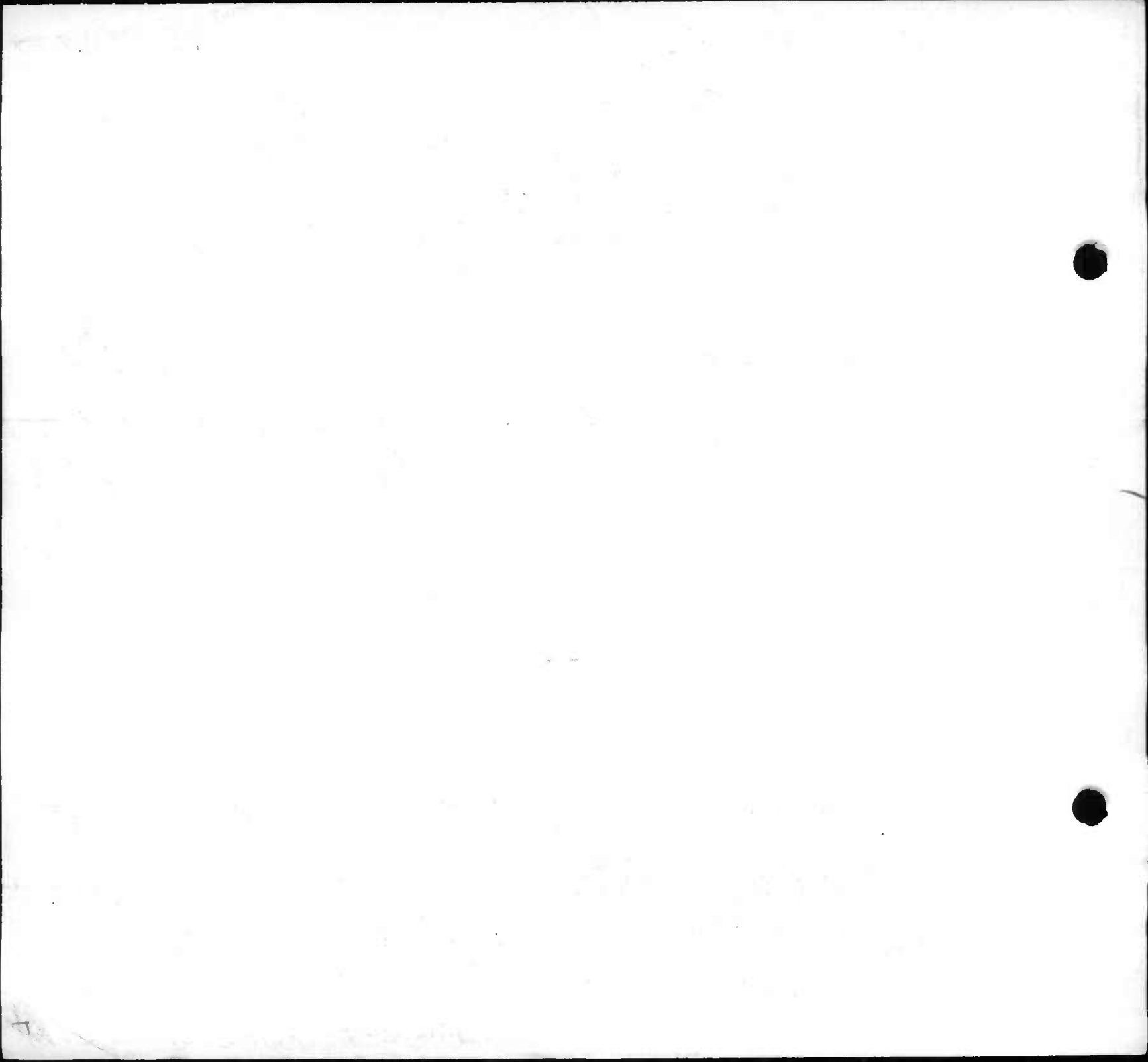
72 00830		BALTIMORE CITY HEALTH DEPARTMENT	
S-530		CERTIFICATE OF DEATH	
BIRTH NO. <span style="float: right;">X REG. NO. 72 00830</span>			
1. NAME OF DECEASED (Type or Print) <b>OMIE ELIZABETH DORSEY SMITH</b>		2. DATE AND HOUR OF DEATH <b>1-20-72 12<sup>00</sup> PM.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b>		A. STATE <b>MARYLAND</b> B. COUNTY <b>FRED.</b>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		C. CITY OR TOWN <b>FREDERICK</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
		E. STREET AND NUMBER <b>102 S. MARKET ST.</b>	
5. SEX <b>FEMALE</b>	6. RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-18-25</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10B. KIND OF BUSINESS OR INDUSTRY	9. AGE (In years last birthday) <b>46</b>
13. FATHER'S NAME <b>William Dorsey</b>		14. MOTHER'S MAIDEN NAME <b>MARY Hall</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>219-12-2063</b>	
		17. INFORMANT <b>Silver Springs, Md</b> <b>Clark W. Smith, Jr 1315 Wheaton Lane</b>	
18. CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Cardio-pul arrest</b>		<b>1 hr</b>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) <b>public repair</b> <b>38 hr</b>	
		(C) <b>Chronic lymphocytic Leukemia</b> <b>5 years</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>2</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>YES</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>12-30-71</b> 19 to <b>1/20/72</b> 19 that (I) (we) last saw the deceased alive on <b>1-20-72</b> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>M. Horan MD</b>		23B. DATE SIGNED <b>1-20-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>M. HORAN M.D.</b>		23D. ADDRESS <b>Johns Hopkins Hosp.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-25-1972</b>	
24C. NAME of CEMETERY or CREMATORY <b>St. Joseph Catholic</b>		24D. LOCATION (City, town, or county) (State) <b>Buckeystown Frederick, Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Beach</b>	
25C. FUNERAL DIRECTOR <b>C. J. Hicks</b>		ADDRESS <b>11 263 W. Patrick St, Fred. Md</b>	

155

•  $\bar{J}_1$  1

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

N-242 72 00831		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00831	
BIRTH NO. <u>72 00831</u>		1. NAME OF DECEASED (Type or Print) <u>Nichols CORINNE</u>		2. DATE AND HOUR OF DEATH <u>January 20, 1972 3:10pm.</u> M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <u>South Baltimore General Hospital</u> <u>300 South Howard St. Balto. Md. 21230</u>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>Baltimore</u>		C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>F.</u> 6. RACE <u>W.</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 12-1902</u> 9. AGE (In years last birthday) <u>69</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Horner</u>	
14. MOTHER'S MAIDEN NAME <u>Jennie Bennett</u>		15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>212-10-4756-A</u>	
17. INFORMANT <u>JOHN NICHOLS</u>		ADDRESS <u>1420 LIGHT ST 2-30</u>		18. <u>2422 I</u> CAUSE OF DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE <u>Heart Block - CHF</u> DUE TO, OR AS A CONSEQUENCE OF:  (B) <u>AS EVD.</u> DUE TO, OR AS A CONSEQUENCE OF:  (C) <u>Thrombosis</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>20 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <u>Jan. 10-72</u> 19 <u>72</u> to <u>Jan. 20</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Jan. 20</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>S. Rios</u> <u>MD.</u> DEGREE		23B. DATE SIGNED <u>Jan. 20-72</u>		23C. PHYSICIAN'S NAME (Type) <u>FELIPE RIOS</u>	
23D. ADDRESS <u>South Baltimore General Hosp.</u> DEGREE		24A. BURIAL, CREMATION, REMOVAL (Specify) <u>JAN 24-72</u>			
24B. NAME OF CEMETERY or CREMATORY <u>LOUDON PARK</u>		24C. LOCATION (City, town, or county) <u>BALTIMORE</u>		24D. ADDRESS <u>2130</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1972</u>		25B. NAME OF REGISTRAR <u>0 0 0</u>		25C. FUNERAL DIRECTOR <u>1216</u> ADDRESS <u>S. CHARLES ST</u>	



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

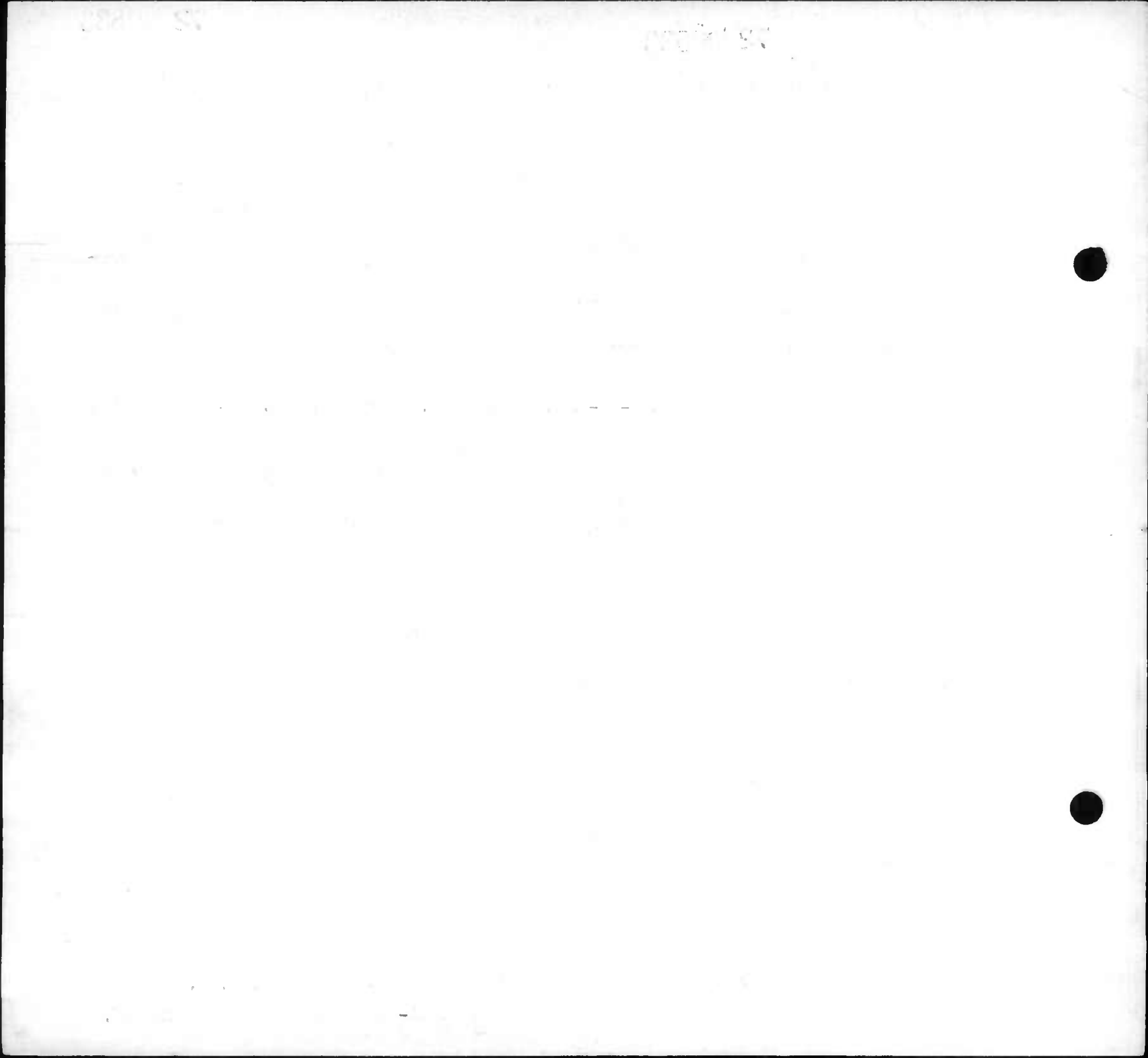
72 00832		BALTIMORE CITY HEALTH DEPARTMENT		72 00832	
4-160 72 00832		CERTIFICATE OF DEATH		REG. NO. _____	
BIRTH NO. _____		1. NAME OF DECEASED (Type or Print) <b>Mr. S. Stewart Hooper</b>		2. DATE AND HOUR OF DEATH <b>January 17, 1972</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>2827 Guilford Ave.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>1203</b>		C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>male</b>		6. RACE <b>white</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>8/28/84</b>		9. AGE (In years last birthday) <b>87</b>		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Accountant</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Self</b>		11. BIRTHPLACE (State or foreign country) <b>Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Samuel J. Hooper</b>		14. MOTHER'S MAIDEN NAME <b>Susan Stewart</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>218 10 0574</b>		17. INFORMANT <b>Mrs. S. Stewart Hooper</b> ADDRESS <b>2827 Guilford Ave</b>	
18. <b>177X I</b> CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Metastatic carcinoma of heart</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Metastatic carcinoma of heart</b> (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 yrs</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (I) (this hospital) attended the deceased from <b>1958</b> to <b>1972</b> and that (I) (we) last saw the deceased alive on <b>12 Jan</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Ernest S. Cross Jr.</b>		23B. DATE SIGNED <b>17 Jan 72</b>		23C. PHYSICIAN'S NAME (Type) <b>Dr. Ernest S. Cross, Jr.</b>	
23D. ADDRESS <b>Medical Arts Bldg.</b>		24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1/20/72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>Druid Ridge Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Pikesville, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Robert M. O. O. O.</b>		25C. FUNERAL DIRECTOR <b>Mitchell-Wiedefeld Home</b> ADDRESS <b>6500 York Rd. Balto. Md. 21212</b>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span style="font-size: 2em;">R-160</span> <span>72 00833</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <div style="display: flex; justify-content: space-between;"> <span>CERTIFICATE OF DEATH</span> <span>REG. NO. 72 00833</span> </div>	
BIRTH NO. <span style="float: right;">1</span> 1. NAME OF DECEASED (Type or Print) <b>EDNA V. RIVERA</b>	
2. DATE AND HOUR OF DEATH <b>JAN. 20 1972 9:05 A.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>SOUTH BALTIMORE GENERAL HOSPITAL 43</b>	
4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>1102</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>208 W. FRANKLIN ST.</b>	
5. SEX <b>F</b> 6. RACE <b>W</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 15, 1913</b> 9. AGE (In years last birthday) <b>58</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b> 10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>
11. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>NEWTON OVERCASH</b> 14. MOTHER'S MAIDEN NAME <b>LENA BELL</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b> 16. SOCIAL SECURITY NO. <b>237-01-1692</b>	
17. INFORMANT <b>Juan P. Rivera</b> ADDRESS <b>208 W. Franklin Street</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>SHOCK BLEEDING</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>or</b> <b>Mixed Pyelonephritis - Perinephric Abscess</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Diabetic Dissecting - Calculeus.</b> (C) <b>operated upon today for removal of pecks - little kidney - hemorrhage</b> II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). 19A. DATE OF OPERATION <b>1/14/71</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>pyelonephritis abscess</b> 20A. AUTOPSY? (Yes or No) <input type="checkbox"/> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <input type="checkbox"/> 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <input type="checkbox"/> 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <input type="checkbox"/> 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <input type="checkbox"/> 21E. INJURY OCCURRED <input type="checkbox"/> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> 21F. HOW DID INJURY OCCUR? <input type="checkbox"/>	
22. I certify that (1) (this hospital) attended the deceased from <b>Dec 20 1971</b> to <b>JAN. 20 1972</b> that (1) (we) last saw the deceased alive on <b>JAN. 20 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. <b>[I saw her from topen]</b> 23A. SIGNATURE <b>Irving Scherlis M.D.</b> 23B. DATE SIGNED <b>JAN. 20 1972</b> 23C. PHYSICIAN'S NAME (Type) <b>IRVING SCHERLIS M.D.</b> 23D. ADDRESS <b>11 E. CHASE ST. BALTIMORE MD 21202</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b> 24B. DATE <b>1/25/72</b> 24C. NAME of CEMETERY or CREMATORY <b>Greenlawn Cemetery</b> 24D. LOCATION (City, town, or county) (State) <b>China Grove, N. C.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b> 25B. NAME OF REGISTRAR <b>Mitchell Wiedefeld</b> 25C. FUNERAL DIRECTOR <b>Home 6500 York Rd.</b> ADDRESS	





## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00834

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Michael Morley</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 21 72</b> M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>38 University Hospital</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 21 72 10:38 a.</b> M.			
6. SEX <b>male</b>				7. RACE <b>White</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>Feb. 16, 1953</b>				10. AGE (In years last birthday) <b>18</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF <b>U.S.A.</b>				13. FATHER'S NAME <b>John G. Morley</b>		14. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>5600 Carroll</b>	
15. MOTHER'S MAIDEN NAME <b>Virginia Lewis</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>215 48 7516</b>	
18. INFORMANT <b>Mrs Virginia L. Franklin Same as # 5</b>				19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Massive bronchopneumonia following shock secondary to multiple injuries</b> (This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.) <b>CAUSE OF DEATH</b> <b>IMMEDIATE CAUSE</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> (A) _____ (B) _____ (C) _____ <b>ANTECEDENT CAUSES</b> <b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>1/23/72</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>HIGHWAY</b>			
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>1 16 72 12:35 a. m.</b>				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			
22F. HOW DID INJURY OCCUR? <b>Subject driver of car - lost control (one car accident)</b>				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>St. Rt. 27 - 9/10 mi. north of Rt. 407</b>			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/21/72</b>				24. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1/23/72</b>				24C. NAME OF CEMETERY or CREMATORY <b>Westminster Cemetery</b>			
24D. LOCATION (City, town, or county) (State) <b>Westminster Maryland</b>				25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>			
25B. NAME OF REGISTRAR <b>Thomas D. Fletcher</b>				25C. FUNERAL DIRECTOR <b>Thomas D. Fletcher</b>			
25D. ADDRESS <b>Westminster, Maryland</b>				25E. ADDRESS			

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

186-11-87

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 00835</span>	
<b>BIRTH NO.</b> <span style="font-size: 1.5em;">Y-562</span>		<span style="font-size: 1.5em;">72 00835</span>		<b>CERTIFICATE OF DEATH</b>	
<b>1. NAME OF DECEASED</b> (Type or Print) <span style="font-size: 1.1em;">Harriett Vainwright</span>			<b>2. DATE AND HOUR OF DEATH</b> <span style="font-size: 1.1em;">22 January 1972   11:15 A.M.</span>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <span style="font-size: 1.1em;">Harbor View Nursing Center 1213 Light Street Baltimore, Maryland 21230</span>			<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <span style="font-size: 1.1em;">Maryland</span> B. COUNTY <span style="font-size: 1.5em;">2102</span> <b>C. CITY OR TOWN</b> <span style="font-size: 1.1em;">Baltimore</span> <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <span style="font-size: 1.1em;">317 South Scott Street</span>		
<b>5. SEX</b> <span style="font-size: 1.1em;">Female</span>	<b>6. RACE</b> <span style="font-size: 1.1em;">White</span>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <span style="font-size: 1.1em;">24 Nov 1924</span>	<b>9. AGE</b> (In years last birthday) <span style="font-size: 1.1em;">47</span>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Practical Nurse</span>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.1em;">Practical Nurse</span>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.1em;">—</span>		<b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.1em;">Cincinnati, Ind.</span>
<b>13. FATHER'S NAME</b> <span style="font-size: 1.1em;">Harry V. Calburn</span>			<b>14. MOTHER'S MAIDEN NAME</b> <span style="font-size: 1.1em;">Jennie (Unknown)</span>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.1em;">No</span>			<b>16. SOCIAL SECURITY NO.</b> <span style="font-size: 1.1em;">220-22-066E</span>		<b>17. INFORMANT ADDRESS</b> <span style="font-size: 1.1em;">Charts from University of Maryland Hospital and Harbor View Convalescent Center</span>
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.] <span style="font-size: 1.1em;">Cerebrovascular Accident</span> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <span style="font-size: 1.1em;">Old Anteroseptal Myocardial Infarct</span>			<b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b> <span style="font-size: 1.1em;">1 January 1972</span>  <span style="font-size: 1.1em;">Unknown</span>  <b>Years</b>		
<b>II</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>					
<b>19A. DATE OF OPERATION</b> <span style="font-size: 1.1em;">—</span>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <span style="font-size: 1.1em;">—</span>		<b>20A. AUTOPSY?</b> (Yes or No) <span style="font-size: 1.1em;">NO</span>	
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (Notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.1em;">—</span>		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location) <span style="font-size: 1.1em;">—</span>	
<b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.) <span style="font-size: 1.1em;">—</span>		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b> <span style="font-size: 1.1em;">—</span>	
<b>22. I certify that (this hospital) attended the deceased from <span style="font-size: 1.1em;">18 January 1972</span> to <span style="font-size: 1.1em;">22 January 1972</span> that (we) last saw the deceased alive on <span style="font-size: 1.1em;">22 January 1972</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <span style="font-size: 1.1em;">Peter H. Rheinsteen, M.D.</span>				<b>23B. DATE SIGNED</b> <span style="font-size: 1.1em;">22 January 1972</span>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <span style="font-size: 1.1em;">Peter H. Rheinsteen, M.D.</span>				<b>23D. ADDRESS</b> <span style="font-size: 1.1em;">Harbor View Nursing Center, 1213 Light Street</span>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <span style="font-size: 1.1em;">Burial</span>		<b>24B. DATE</b> <span style="font-size: 1.1em;">1/25/72</span>		<b>24C. NAME OF CEMETERY or CREMATORY</b> <span style="font-size: 1.1em;">Glen Haven Cem.</span>	
<b>24D. LOCATION</b> (City, town, or county) (State) <span style="font-size: 1.1em;">Glen Burnie, Md.</span>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <span style="font-size: 1.1em;">JAN 25 1972</span>			
<b>25B. NAME OF REGISTRAR</b> <span style="font-size: 1.1em;">—</span>		<b>25C. FUNERAL DIRECTOR</b> <span style="font-size: 1.1em;">—</span>		<b>ADDRESS</b> <span style="font-size: 1.1em;">901 Hollands St. 21223</span>	

ST 57

ST 58

ST 59

ST 60

ST 61

ST 62

ST 63

ST 64

ST 65

ST 66

ST 67

ST 68

ST 69

ST 70

ST 71

ST 72

ST 73

ST 74

ST 75

ST 76

ST 77

ST 78

ST 79

ST 80

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

1. NAME OF DECEASED (Type or Print) <b>DALLAM, MARGARET G.</b>		2. DATE AND HOUR OF DEATH <b>1-21-1972 3:30 P.M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b> <b>44</b>		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>HARFORD</b> C. CITY OR TOWN <b>FALLSTON</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> E. STREET AND NUMBER <b>2704 MDR. COURT</b>	
5. SEX <b>F</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-23-06</b>
9. AGE (in years last birthday) <b>65</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>FRANK STANDISH BORD</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH KING</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>213-32-7363</b>	
17. INFORMANT <b>JACKSON P. DALLAM</b>		ADDRESS <b>Same as #4</b>	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>HYPERCALCEMIA + URINARY INFECTION</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>MULTIPLE MYELOMA</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>DAYS</b> <b>3YRS</b>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <b>0-1-72</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <b>No</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)	
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>01-16-1972</b> to <b>01-21-1972</b> that (I) (we) last saw the deceased alive on <b>01-21-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Ghassan Nahas</b>		23B. DATE SIGNED <b>01-21-1972</b>	
23C. PHYSICIAN'S NAME (Type) <b>GHASSAN NAHAS M.D.</b>		23D. ADDRESS <b>UNION MEMORIAL HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-25-72</b>	
24C. NAME of CEMETERY or CREMATORY <b>DULANEY VALLEY MEMORIAL</b>		24D. LOCATION (City, town, or county) (State) <b>TIMONIUM MD</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. FUNERAL DIRECTOR <b>Wm. Cook &amp; Bracks</b>	
25C. NAME OF REGISTRAR <b>1-972000</b>		ADDRESS <b>Towson, Md.</b>	

1. The first part of the report is a general description of the project. It includes a statement of the purpose of the project, a description of the scope of the project, and a list of the objectives of the project. The second part of the report is a description of the methodology used in the project. It includes a description of the data sources, a description of the data collection methods, and a description of the data analysis methods. The third part of the report is a description of the results of the project. It includes a description of the findings of the project, a description of the conclusions of the project, and a description of the recommendations of the project. The fourth part of the report is a description of the limitations of the project. It includes a description of the limitations of the data, a description of the limitations of the methodology, and a description of the limitations of the conclusions. The fifth part of the report is a description of the future work. It includes a description of the future work that is planned, a description of the future work that is needed, and a description of the future work that is possible.

2. The second part of the report is a description of the methodology used in the project. It includes a description of the data sources, a description of the data collection methods, and a description of the data analysis methods. The third part of the report is a description of the results of the project. It includes a description of the findings of the project, a description of the conclusions of the project, and a description of the recommendations of the project. The fourth part of the report is a description of the limitations of the project. It includes a description of the limitations of the data, a description of the limitations of the methodology, and a description of the limitations of the conclusions. The fifth part of the report is a description of the future work. It includes a description of the future work that is planned, a description of the future work that is needed, and a description of the future work that is possible.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00837

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (GEORGE) JOE LOUIS HENDRIX (HENDRICKS)		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) BON SECOURS HOSPITAL (DOA)		3. DATE PRONOUNCED DEAD Month Day Year Hour January 22, 1972 9:50 P. M.	
6. SEX Male		7. RACE Negro	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN Baltimore	
9. DATE OF BIRTH Aug, 28, 1926		10. AGE (In years last birthday) 45 If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) Windsor, North Carolina		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		14B. KIND OF BUSINESS OR INDUSTRY United Fruit Co.	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. 217-12-8151	
18. INFORMANT Maude Russell		ADDRESS 2403 Guilford Ave.	
19. E965 X DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH Gunshot wound of neck  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION 2		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) lavern	
22D. TIME OF INJURY (APPROX.) 1-22-72 9:35 P. m.		22C. WHERE DID INJURY OCCUR? 2432 Fredrick Avenue 2004	
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? Shot during altercation	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE: <i>Ronald N. Kornblum</i> M.D. EXAMINER'S NAME (Type): Ronald N. Kornblum, M.D.  CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: 1/23/72			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1-28-72	
24C. NAME OF CEMETERY or CREMATORY Arbutus Menorial Pk.		24D. LOCATION (City, town, or county) (State) Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT. JAN 25 1972		25B. NAME OF REGISTRAR Robert E. Zuber, M.D.	
25C. FUNERAL DIRECTOR Morton & Dyett Funeral Homes, Inc.		ADDRESS 1701 Laurens Street	

35 00837

35 00837

(12-11-52)

January 1, 1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

1953

*Handwritten signature*

1953

1953

1953

1953

1953



1

72 00838

BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00838

REG. NO.

R-500  
BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>HENRY ROANE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>00 1828 Thomas Avenue</b>		3. DATE PRONOUNCED DEAD Month Day Year <b>January 22, 1972</b> Hour <b>9:18 A.</b> M.	
6. SEX <b>Male</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>Negro</b>		C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>July 17, 1902</b>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) <b>69</b>		E. STREET AND NUMBER <b>1828 Thomas Avenue</b>	
11. BIRTHPLACE (State or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Industry</b>	
14B. KIND OF BUSINESS OR INDUSTRY <b>Steel Industry</b>		15. MOTHER'S MAIDEN NAME <b>Unknown</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>274-09-6369</b>	
18. INFORMANT <b>Mrs. Edna Roane</b>		ADDRESS <b>1828 Thomas Avenue</b>	
19. <b>4/12/74</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).		CAUSE OF DEATH <b>Arteriosclerotic cardiovascular disease</b>  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:	
20A. DATE OF OPERATION <b>0</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>no</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE: <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type): <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED: <b>1/23/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-29-72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Canton Cemetry</b>		24D. LOCATION (City, town, or county) (State) <b>Canton, Ohio</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 25 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Morton &amp; Dyett F. H.</b>		ADDRESS <b>1701 Laurens St.</b>	

1 9 7 2 0 0 0 0 8 3 6

35 00833

35 00833

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

B-240		72 00839		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00839	
1. NAME OF DECEASED (Type or Print) <u>MRS. PEARL BEASLEY</u>				2. DATE AND HOUR OF DEATH <u>JANUARY 23-72</u> <u>6:15 A.M.</u>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>1601</u>			
FULL NAME OF HOSPITAL OR INSTITUTION <u>44</u> <u>UNION MEMORIAL HOSPITAL</u>				C. CITY OR TOWN <u>BALTIMORE</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER <u>2525 W. BELVEDERE AVENUE</u>			
5. SEX <u>F</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>05-21-81</u>	9. AGE (In years last birthday) <u>90</u>	10. Under 1 Yr. Months Days Hours Min. 11. Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				11. BIRTHPLACE (State or foreign country) <u>MACON, GEORGIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>UNKNOWN IKE</u>				14. MOTHER'S MAIDEN NAME <u>(UNKNOWN) SUSAN BOSTIC</u>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <u>215-32-0285</u>		17. INFORMANT <u>Dr. Albert H. Dudley - 6203-Blackburn Lane</u>	
18. <u>440.91</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Pulmonary edema</u> (B) <u>Heart failure</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>Myocardial infarction</u>			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, home, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <u>12/12/1911</u> to <u>1/23/1972</u> that (I) (we) last saw the deceased alive on <u>1/23/1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <u>[Signature]</u>				23B. DATE SIGNED <u>1/23/72</u>		23C. PHYSICIAN'S NAME (Type) <u>CESAR VILLARON</u>	
23D. ADDRESS <u>33 rd and Calvert St.</u>				23E. MED. DIRECTOR <input type="checkbox"/>		23F. STAFF PHYS. <input checked="" type="checkbox"/>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-26-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Nit. Auburn Cem.</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore Md.</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 25 1972</u>		25B. NAME OF REGISTRAR <u>Robert F. Jones, M.D.</u>		25C. FUNERAL DIRECTOR <u>Mortgny Dyett F. H.</u>		25D. ADDRESS <u>1701-1705 St.</u>	

11/29/69

827 N. Arlington Ave.

Unknown IKE

Alcorn (Georgia)

(Unknown) 2nd in Boston

1-20-72 at Harbor (San. Ex. 114)

1-20-72 at Harbor (San. Ex. 114)

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

7-535 72 00840		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <span style="background-color: black; color: black;">[REDACTED]</span> 72 00840	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>FONTAINE, OGDEN</u>		2. DATE AND HOUR OF DEATH <u>1/23/72</u> <u>9 30</u> A.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>MD.</u> B. COUNTY <u>CITY</u>		C. CITY OR TOWN <u>BALITOMRE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>HARBOR VIEW NURSING CENTER</u> <u>1213 LIGHT STREET</u>		E. STREET AND NUMBER <u>1213 LIGHT STREET</u>			
5. SEX <u>M</u>	6. RACE <u>N</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <u>1/28/09</u>	9. AGE (In years last birthday) <u>63</u>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>N.J.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Ogden Fontaine</u>		14. MOTHER'S MAIDEN NAME <u>Vashie Mitchell</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.		17. INFORMATION ADDRESS <u>CHART (Hilda Locke - 6047 Baltimore St.</u>	
18. <u>43691</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE <u>Pulmonary Congestion</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>Cerebral Vascular accident</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>—</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Dec 1971</u> <u>Dec 1971</u> <u>—</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>NO</u>	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner) <u>NO</u>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (1) (this hospital) attended the deceased from <u>18 Jan</u> 19 <u>72</u> to <u>23 Jan</u> 19 <u>72</u> that (2) (we) last saw the deceased alive on <u>21 Jan</u> 19 <u>72</u> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Edwin C. Fulton, MD.</u>		23B. DATE SIGNED <u>25 Jan 1972</u>		23C. PHYSICIAN'S NAME (Type)	
23D. ADDRESS					
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <u>1/27/72</u>		24C. NAME OF CEMETERY or CREMATORY <u>West Park, Md.</u>	
24D. LOCATION (City, town, or county) (State)					
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1972</u>		25B. NAME OF REGISTRAR <u>[Signature]</u>		25C. FUNERAL DIRECTOR <u>[Signature]</u>	
25D. ADDRESS					

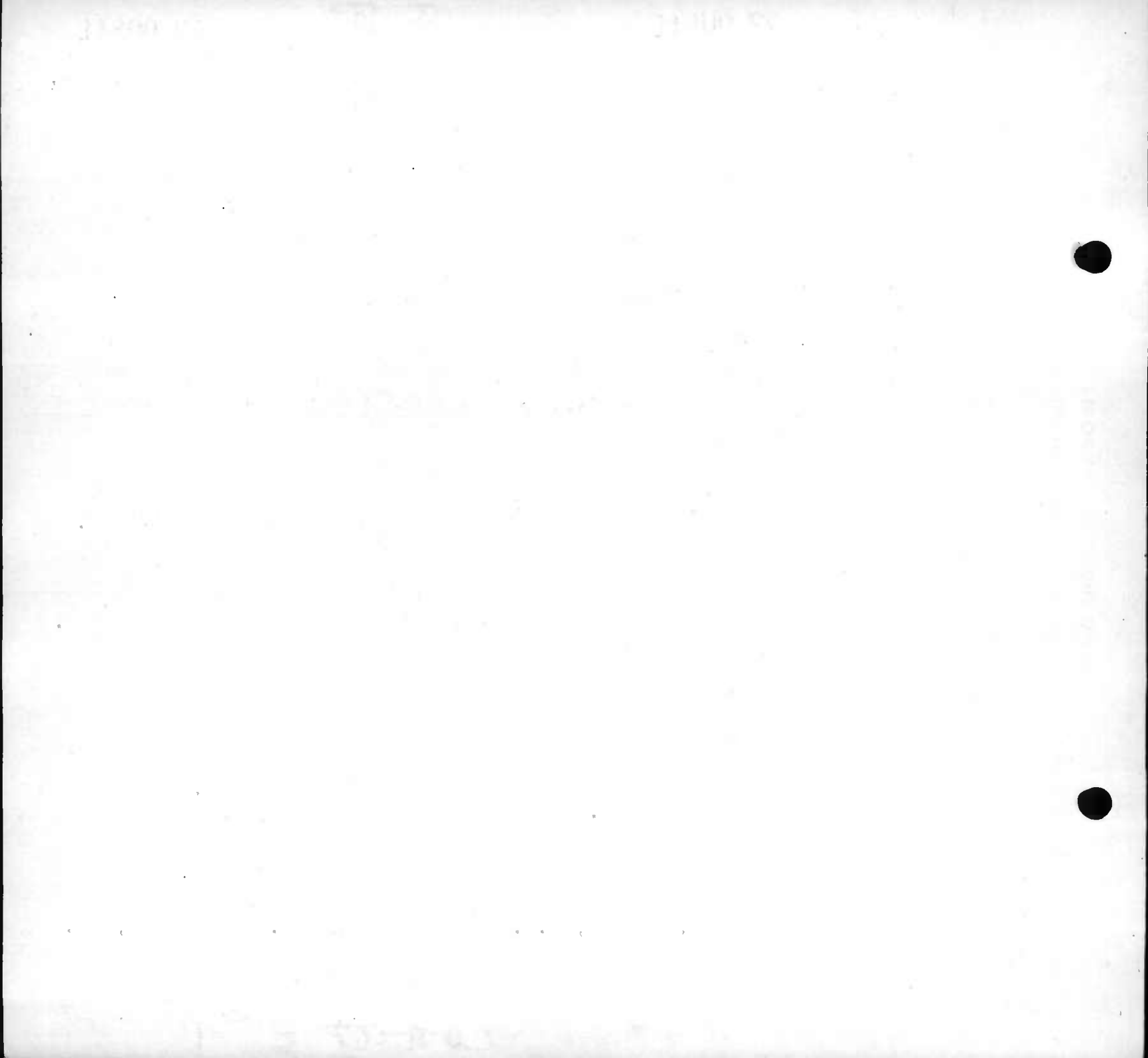
1/19/72

935 W. Lee St. 21230

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

P-612 72 00841'		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00841'	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <b>AGRETHA G. PROPST</b>		2. DATE AND HOUR OF DEATH <b>1-24-72 11:00 A.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>701</b>		C. CITY OR TOWN <b>BALTIMORE</b>	
FULL NAME OF HOSPITAL OR INSTITUTION <b>00 526 N. CURLEY ST.</b>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <b>F</b>		6. RACE <b>W</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>12-19-1903</b>		9. AGE (In years last birthday) <b>68</b>		If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>FREDERICK FOUNTAIN</b>		14. MOTHER'S MAIDEN NAME <b>FLORENCE SAY</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>220.05.0036</b>		17. INFORMANT <b>Mr. Hubert R. Propst - 526 N. Curley St.</b>	
18. <b>410.9 I</b>		CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b>		<b>3 days</b>	
ANTECEDENT CAUSES		(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerotic Cardio-vascular Disease</b>		<b>2 yrs.</b>	
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(C)			
II		OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<b>Pulmonary Emphysema</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>No</b>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>June 19 49</b> to <b>Jan. 19 72</b> , that (I) (we) last saw the deceased alive on <b>Jan. 20 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Clarence W. LeDoux MD</b>				23B. DATE SIGNED <b>1/26/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>Clarence W. LeDoux, M.D.</b>				23D. ADDRESS <b>3023 Eastern Ave. Baltimore, Md.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-27-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>BALTIMORE CEMETERY</b>	
24D. LOCATION (City, town, or county) <b>BALTO., MD.</b>		24E. LOCATION (State) <b>MD.</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>		25B. NAME OF REGISTRAR <b>Clarence W. LeDoux</b>		25C. FUNERAL DIRECTOR <b>2334 Jefferson St.</b>	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-556 72 00842		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00842	
BIRTH NO.		1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH	
		MILTON P. SHANNON		1-22-72 5:30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)		
FULL NAME OF HOSPITAL OR INSTITUTION			A. STATE B. COUNTY		
IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION			MARYLAND CITY 602		
33 THE JOHNS HOPKINS HOSPITAL BALTIMORE, MD 21205			C. CITY OR TOWN D. INSIDE CITY LIMITS?		
			BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			E. STREET AND NUMBER		
			2409 E. JEFFERSON STREET		
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. Under 1 Yr. Months Days
MALE	WHITE	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	06-29-94	77	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
GUARD		REFRIGERATION		MARYLAND	
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME		
DAVID SHANNON			MARY V. —		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
No.		215-09-6824 A		Mrs. Josephine V. Shannon - 2409 Jefferson St.	
18. CAUSE OF DEATH			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		
(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)			Allergic reaction		
ANTECEDENT CAUSES			(B) DUE TO, OR AS A CONSEQUENCE OF:		
DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			Hypoxemia		
			(C) Pneumonia; CVA		
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
2				YES	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
		While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			
22. I certify that (I) (this hospital) attended the deceased from 1-20-1972 to 1-22-1972 that (I) (we) last saw the deceased alive on 1-22-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE			23B. DATE SIGNED		
James T. Martin			1-22-72		
23C. PHYSICIAN'S NAME (Type)			23D. ADDRESS		
JAMES T. MARTIN M.D.			THE JOHNS HOPKINS HOSPITAL		
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY	
BURIAL		1-26-72		LOUDON PARK Cem.	
				BALTO., MD.	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR ADDRESS	
JAN 26 1972		J. T. Martin		Stephen Miller - 2334 Jefferson St.	

15

15

15

15

15

15

15

15

15

15

15

15

15

15

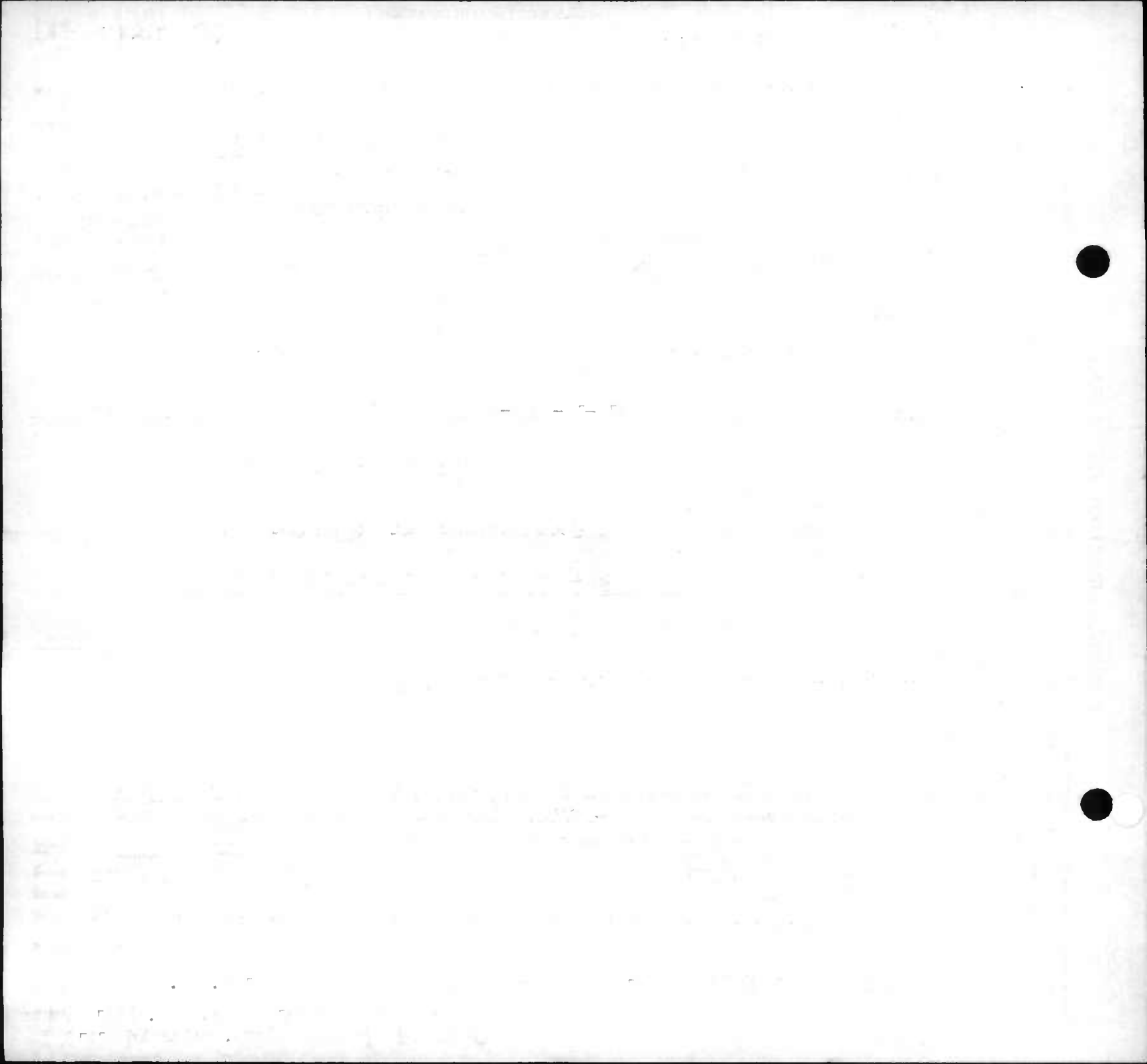
15

15

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>G-653</b></span> <span><b>72 00843</b></span> <span><b>BALTIMORE CITY HEALTH DEPARTMENT</b></span> </div> <div style="display: flex; justify-content: space-between;"> <span><b>BIRTH NO.</b></span> <span><b>CERTIFICATE OF DEATH</b></span> <span><b>REG. NO. 72 00843</b></span> </div>					
<b>1. NAME OF DECEASED</b> (Type or Print) <b>GRANADIER, EDNA MARIE</b>			<b>2. DATE AND HOUR OF DEATH</b> <b>Jan 21<sup>st</sup>, 72 4<sup>30</sup> AM</b>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b> <b>44</b>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) <b>A. STATE</b> <b>MD</b> <b>B. COUNTY</b> <b>BALTIMORE</b> <b>2706</b> <b>C. CITY OR TOWN</b> <b>BALTIMORE</b> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <b>6211 MARIETTA AV.</b> <b>321 E. CALVERT</b> <b>21214</b>		
<b>5. SEX</b> <b>F</b>	<b>6. RACE</b> <b>W</b>	<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <b>02.19.89</b>	<b>9. AGE</b> (In years last birthday) <b>82</b>	<b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>NONE</b>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>NONE</b>			<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <b>MARYLAND</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>U.S.A</b>
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A</b>			<b>13. FATHER'S NAME</b> <b>JOHN E. ELINE</b>		
<b>14. MOTHER'S MAIDEN NAME</b> <b>ANNA BISKER</b>			<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		
<b>16. SOCIAL SECURITY NO.</b> <b>217-16-5468</b>			<b>17. INFORMANT</b> <b>DAUGHTER</b>		
<b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>153,014,250.9</b> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>(A) IMMEDIATE CAUSE</b> <b>POST-OP SHOCK</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(B) CARCINOMA OF CECUM</b> <b>DUE TO, OR AS A CONSEQUENCE OF:</b> <b>(C) DIAPHRAGMATIC HERNIA</b> <b>DIABETES</b>			<b>ADDRESS</b> <b>SAME AS ABOVE</b>		
<b>19. CAUSE OF DEATH</b> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>					
<b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <b>II</b> <b>DIABETES</b>					
<b>19A. DATE OF OPERATION</b> <b>1.18.72</b>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>INTestinal Obstruction</b>		<b>20A. AUTOPSY?</b> (Yes or No) <b>No</b>	
<b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>			
<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg, etc.)		<b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)			
<b>21D. TIME OF INJURY</b> (APPROX.) (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		<b>21F. HOW DID INJURY OCCUR?</b>	
<b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>01.02.72</b> <b>19</b> <b>to</b> <b>1.21.72</b> <b>19</b> <b>that (I) (we) last saw the deceased alive on</b> <b>4 PM 1.21.72</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>					
<b>23A. SIGNATURE</b> <b>S. Rafati</b>				<b>23B. DATE SIGNED</b> <b>1.21.72</b>	
<b>23C. PHYSICIAN'S NAME</b> (Type) <b>SALAH RAFATI M.D.</b>				<b>23D. ADDRESS</b> <b>UNION MEMORIAL HOSPITAL</b>	
<b>24A. BURIAL CREMATION, REMOVAL</b> (Specify) <b>BURIAL</b>		<b>24B. DATE</b> <b>1/24/72</b>		<b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Holy Redeemer Cemetery</b>	
<b>24D. LOCATION</b> (City, town, or county) (State) <b>Balto. Md.</b>		<b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 26 1972</b>			
<b>25B. NAME OF REGISTRAR</b> <b>Shimunek Funeral Homes, Inc.</b>		<b>25C. FUNERAL DIRECTOR</b> <b>3331 Brehms Lane, Balto Md 21213</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00844</span>	
72 00844				CERTIFICATE OF DEATH	
BIRTH NO. <span style="float: left;">D-150</span>					
1. NAME OF DECEASED (Type or Print) <b>DIVEN, ANNA MARGARET</b>			2. DATE AND HOUR OF DEATH <b>1-20-72 3:40 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>THE UNION MEMORIAL HOSPITAL</b>			4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTIMORE</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2833 LAKE AVENUE 21213</b>		
5. SEX <b>F</b>	6. RACE <b>W.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-7-91</b>		9. AGE (In years last birthday) <b>80</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NONE</b>		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>JULIUS BUETTNER</b>			14. MOTHER'S MAIDEN NAME <b>ANNA CLOVER</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>213-52-8454</b>		17. INFORMANT <b>Charles Klein (son) 8313 Nunley Drive</b>	
18. <b>410.01</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>MICROCARDIAL INFARCTION</b> DUE TO, OR AS A CONSEQUENCE OF: (B) <b>ASCVD - HYPERTENSION</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
19A. DATE OF OPERATION <b>0</b>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1-20</b> 19 <b>72</b> to <b>1-20</b> 19 <b>72</b> that (I) (we) lost saw the deceased alive on <b>1-20</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Julio A. DeJoy</i>			23B. DATE SIGNED <b>1-20-72</b>		
23C. PHYSICIAN'S NAME (Type) <b>JULIO A. DEJOY, M.D.</b>			23D. ADDRESS <b>THE UNION MEMORIAL HOSPITAL</b>		
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/24/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Zion Evangelical Lutheran Cemetery</b>	
24D. LOCATION <b>Balto., Md.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>			
25B. NAME OF REGISTRAR <b>Schimunek Funeral Homes, Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>3331 Brehms Lane, Balto Md 21213</b>			

11-11-87

11-11-87

11-11-87

11-11-87

11-11-87

11-11-87

11-11-87

11-11-87

11-11-87

11-11-87

11-11-87

11-11-87

11-11-87

11-11-87

11-11-87

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. of a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 00845	
BIRTH NO. <b>7-610</b>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Michael Farbo</b>		2. DATE AND HOUR OF DEATH <b>1/21/72</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <b>4123 Balfern Ave.</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>2643</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>4123 Balfern Ave. Balto. Md. 21213</b>	
5. SEX <b>M</b>	6. RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/11/23</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Car man</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Railroad</b>	9. AGE (In years last birthday) <b>48</b>
13. FATHER'S NAME <b>Joseph Farbo</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>yes WW II</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. SOCIAL SECURITY NO. <b>234-24-6409</b>		17. INFORMANT <b>Catherine Farbo (wife)</b>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>410.01</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Acute Myocardial Infarction</b>		ADDRESS <b>same as above</b>	
19. ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Arteriosclerosis Heart disease</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 hours</b>	
20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II Hypertension</b>		21. PROBABLE CAUSE OF DEATH <b>Myocardial Infarction</b>	
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	
21E. INJURY OCCURRED		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>May 1959</b> to <b>Jan 1972</b> , that (I) ( <del>we</del> ) last saw the deceased alive on <b>1-13-72</b> and that in ( <del>my</del> ) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did</del> ) (did not) view the body after death.		23A. SIGNATURE <b>Lester Lebo M.D.</b>	
23B. DATE SIGNED		23C. PHYSICIAN'S NAME (Type) <b>Dr. Lester Lebo</b>	
23D. ADDRESS <b>Medical Arts Bldg. Balto Md.</b>		23E. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys.	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1/24/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Holy Redeemer Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Balto. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>		25B. NAME OF REGISTRAR <b>Schimunek</b>	
25C. FUNERAL DIRECTOR <b>Schimunek Funeral Homes, Inc. 3331 Brehms Lane, Balto Md 21213</b>		25D. ADDRESS	

100-100000

100-100000

RECEIVED 100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000

100-100000



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <u>72 00846</u>	
BIRTH NO. <u>72 00846</u>				CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>CHARLES P. SIEBERT</u>			2. DATE AND HOUR OF DEATH <u>1/22/72</u> <u>12:45 PM</u>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>48 Md. General Hospital 1-31-72</u>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>BALTIMORE</u>		
5. SEX <u>Male</u>			6. RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH <u>01-30-86</u>			9. AGE (In years last birthday) <u>85</u> <u>84</u>		10. IF UNDER 1 Yr. Months Days
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Charles F. Siebert</u>			14. MOTHER'S MAIDEN NAME <u>Annie Green</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>216-114-7168</u>		17. INFORMANT <u>Mrs. Charles Siebert</u> ADDRESS <u>21162</u>
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Respiratory + Cardiac arrest</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>15 min</u>		
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>Carcinoma of Colon (sigmoid)</u>			(B) <u>Due to, or as a consequence of:</u>		
(C) <u>Due to, or as a consequence of:</u>					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).					
19A. DATE OF OPERATION <u>1/18/72 + 1/19/72</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Carcinoma of Sigmoid Colon</u>		20A. AUTOPSY? (Yes or No) <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/22</u> 19 <u>72</u> to <u>1/22</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/22</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lois R. H. M.D.</u>			23B. DATE SIGNED <u>1/22/72</u>		23C. PHYSICIAN'S NAME (Type) <u>Lois R. H. M.D.</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>			24B. DATE <u>1/26/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Baltimore Cemetery</u>
24D. LOCATION <u>Baltimore</u>			24E. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1972</u>		24F. NAME OF REGISTRAR <u>Lois R. H. M.D.</u>
24G. FUNERAL DIRECTOR <u>Lois R. H. M.D.</u>			24H. ADDRESS <u>7401 Belair Rd. Balto.</u>		24I. ADDRESS <u>21236</u>

1-31-1972 - Correction Form from Funeral Director - Lassahn Funeral Home,  
7401 Belair Road  
Baltimore, Maryland 21236

HRS

G-650

72 00847

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00847

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>EDWARD GREEN</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>UNION MEMORIAL HOSPITAL</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 22, 1972 3:00 P.</b>	
6. SEX <b>Male</b>				7. RACE <b>White</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				C. CITY OR TOWN <b>Baltimore</b>	
9. DATE OF BIRTH <b>4/13/06</b>				10. AGE (In years lost birthday) <b>65</b>	
11. BIRTHPLACE (State or foreign country) <b>Ind</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>				14B. KIND OF BUSINESS OR INDUSTRY <b>?</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>				17. SOCIAL SECURITY NO. <b>218-03-1360</b>	
18. INFORMANT <b>Lillian R. Green</b>				ADDRESS <b>(Same)</b>	
19. <b>4-12-41</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Arteriosclerotic cardiovascular disease</b> (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>0</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)				22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?				22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>  ACTUAL SIGNATURE <b>Ronald N. Kornblum, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Ronald N. Kornblum, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/23/72</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/25/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Western</b>	
24D. LOCATION (City, town, or county) (State) <b>Balto, Ind.</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>			
25B. NAME OF REGISTRAR <b>Robert E. Fahey, M.D.</b>		25C. FUNERAL DIRECTOR <b>Paul E. Chenevix</b>			
25D. ADDRESS <b>3617 Chestnut Ave</b>					

1120-85

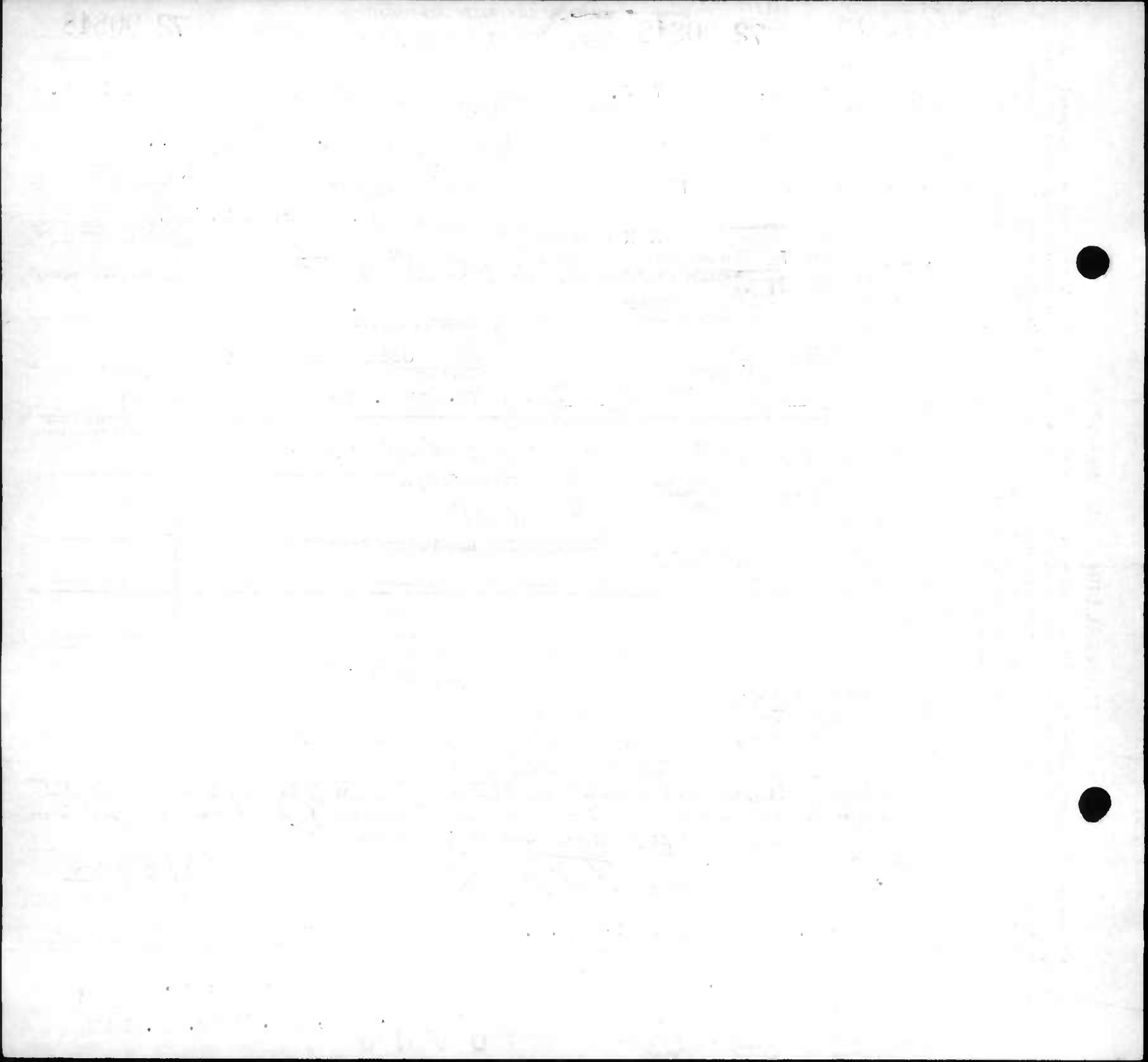
1120-85



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

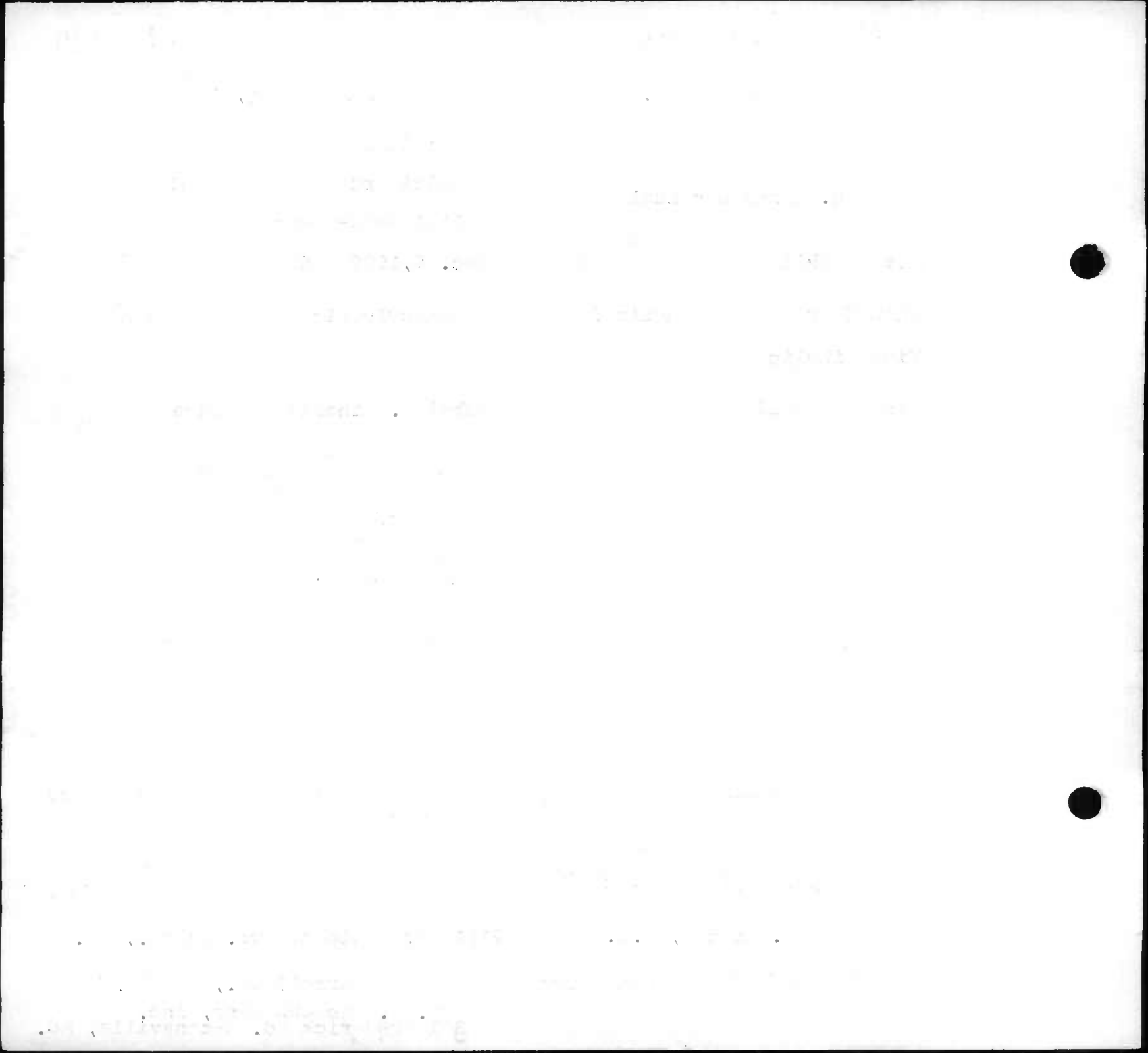
BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 00848</u>	
P-630 72 00848		CERTIFICATE OF DEATH	
BIRTH NO. <u>1</u>		DATE AND HOUR OF DEATH <u>1/24/72</u> <u>7:30 p.m.</u>	
1. NAME OF DECEASED (Type or Print) <u>PURDY, ANTHONY J.</u>		2. DATE AND HOUR OF DEATH	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <u>MARYLAND</u> B. COUNTY <u>807</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>JOHNS HOPKINS HOSPITAL</u>		C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		E. STREET AND NUMBER <u>1509 N. CAROLINE STREET</u>	
5. SEX <u>MALE</u>	6. RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>02/02/27 93</u> 9. AGE (in years last birthday) <u>85</u> 78
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Barber</u>	
11. BIRTHPLACE (State or foreign country) <u>MASS.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>CHARLES PURDY</u>		14. MOTHER'S MAIDEN NAME <u>JOSEPHINE ?</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>Yes 1920--1923</u>		16. SOCIAL SECURITY NO. <u>213-05-2621</u>	
17. INFORMANT <u>Mrs. Mae C. Purdy</u>		ADDRESS <u>(Same)</u>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <u>myocardial infarction</u> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <u>HASCVD</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION <u>0</u>	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <u>NO</u>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>NO</u>
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>1/24</u> 19 <u>72</u> to <u>1/24</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/24</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Penelope P. Scott M.D.</u> Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>			23B. DATE SIGNED <u>1/24/72</u>
23C. PHYSICIAN'S NAME (Type) <u>DR. PENELOPE SCOTT M.D.</u>			23D. ADDRESS <u>The Johns Hopkins Hospital</u>
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	24B. DATE <u>1/28/72</u>	24C. NAME of CEMETERY or CREMATORY <u>Gettysburg National Cemetery</u>	24D. LOCATION (City, town, or county) (State) <u>Gettysburg, Pa.</u>
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>	25C. FUNERAL DIRECTOR <u>Leonard J. Ruck, Inc. Balto. Md. 21211</u>



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

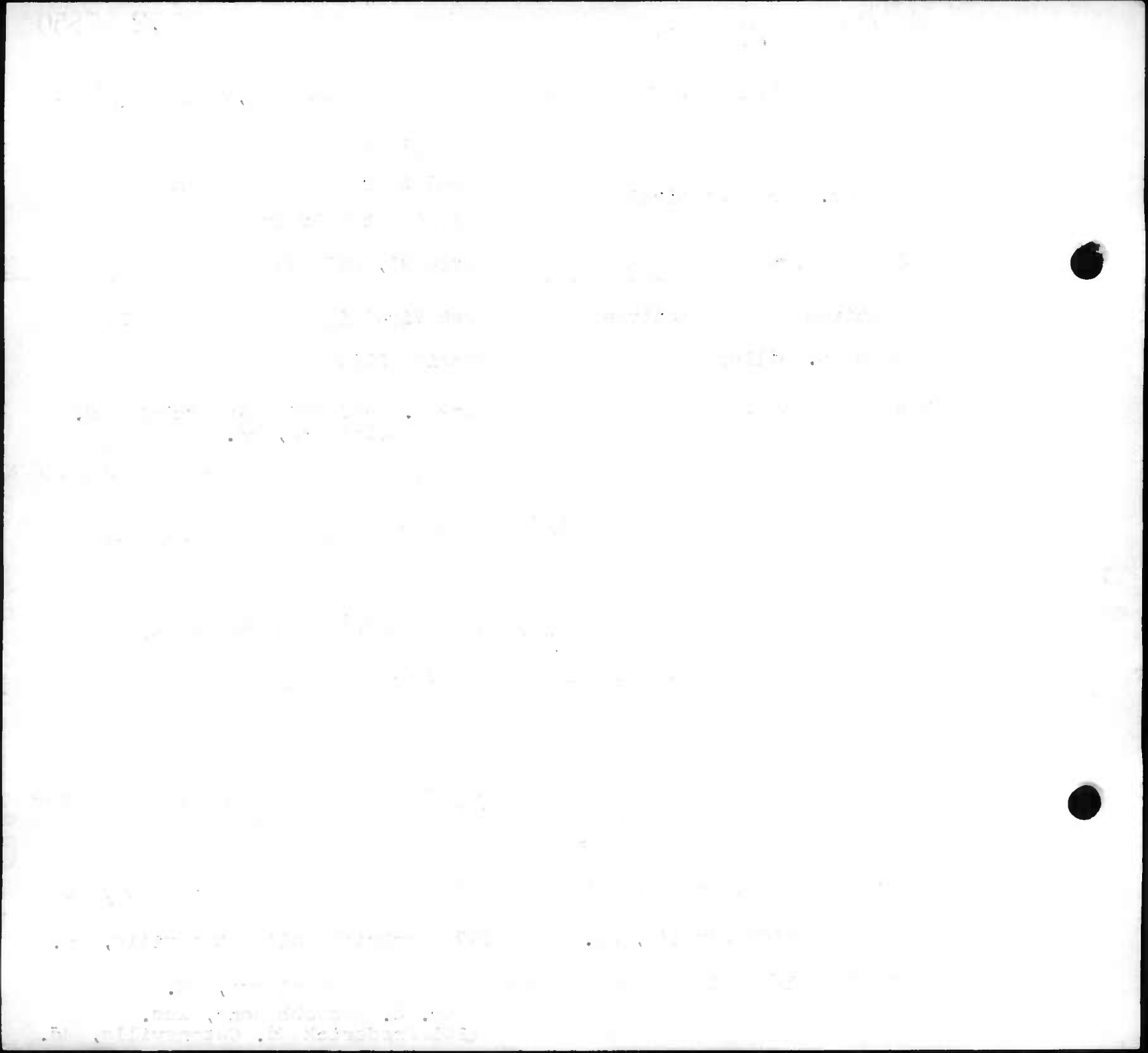
M-420		72 00849		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00849	
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH			
ANTHONY M. MIHALIC				JANUARY 22, 1972			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)			
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  40 St. Agnes Hospital				A. STATE		B. COUNTY	
				Maryland		2834	
C. CITY OR TOWN		D. INSIDE CITY LIMITS?		E. STREET AND NUMBER			
Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1101 Cooks Lane			
5. SEX	6. RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday)	10. UNDER 1 Yr. Months: Days	11. UNDER 24 Hrs. Hours: Min.	
Male	White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	Dec. 9, 1909	62			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Chauffeur		Retired		Pennsylvania		USA	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
Vito Mihalic							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Yes WW II				Mabel E. Mihalic		Same	
18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE			
				DUE TO, OR AS A CONSEQUENCE OF:			
				(B) DUE TO, OR AS A CONSEQUENCE OF:			
				(C) DUE TO, OR AS A CONSEQUENCE OF:			
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 19 100 to 1-22 19 72 that (I) (we) last saw the deceased alive on 1/5 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE				23B. DATE SIGNED			
Leonard M. Lister, M.D.				1/24/72			
23C. PHYSICIAN'S NAME (Type)		23D. ADDRESS		23E. FUNERAL DIRECTOR		ADDRESS	
Leonard M. Lister, M.D.		7111 Park Heights Ave., Balto., Md.		Edw. S. MacNabb Sons, Inc.		3010 Frederick Rd., Catonsville, Md.	
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME of CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		1/25/72		Lake View		Carroll Co., Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR			
JAN 26 1972		Robert F. Taylor, M.D.		Edw. S. MacNabb Sons, Inc.		3010 Frederick Rd., Catonsville, Md.	





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>M-460</b>		72 00850		BALTIMORE CITY HEALTH DEPARTMENT		72 00850	
1. NAME OF DECEASED (Type or Print) <b>BENJAMIN FRANKLIN MILLER</b>				2. DATE AND HOUR OF DEATH <b>JANUARY 23, 1972</b> <b>12</b> P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 St. Agnes Hospital</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>Maryland</b> B. COUNTY <b>2047</b>			
5. SEX <b>Male</b>		6. RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 31, 1897</b> <b>74</b>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>West Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John D. Miller</b>				14. MOTHER'S MAIDEN NAME <b>Bessie Ellis</b>			
15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT <b>Mary L. Reed 3449 Old Orchard Rd.</b>			
18. <b>410914019.0</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  [This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.]  ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>Pulm TB - healed</b>				CAUSE OF DEATH <b>Baltimore, Md.</b>  (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Myocardial Infarction</b>  (B) <b>Arteriosclerotic Cardio Vascular system</b> DUE TO, OR AS A CONSEQUENCE OF:  (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b>	
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>7/8</b> 19 <b>72</b> to <b>1/23</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>12/1</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>Cliff Ratliff, Jr.</b>				23B. DATE SIGNED <b>1/24/72</b>		23C. PHYSICIAN'S NAME (Type) <b>Edw. S. MacNabb Sons, Inc.</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/27/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Loudon Park</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>Edw. S. MacNabb Sons, Inc.</b> <b>301 Frederick Rd. Catonsville, Md.</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<b>L-620</b> BIRTH NO.		<b>72 00851</b> BALTIMORE CITY HEALTH DEPARTMENT		<b>CERTIFICATE OF DEATH</b>		REG. NO. <b>72 00851</b>	
1. NAME OF DECEASED (Type or Print) <b>LERCH JOHN L.</b>				2. DATE AND HOUR OF DEATH <b>January 23, 1972 11:10 A.M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location) <b>Veterans Administration Hospital 23 Loch Raven</b>				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>1121 DeLong Road</b>			
5. SEX <b>MALE</b>	6. RACE <b>CAUCASIAN</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>5/9/95</b>	9. AGE (In years last birthday) <b>76</b>	10. If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist Welder</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>US Gov't.</b>		11. BIRTHPLACE (State or foreign country) <b>FREDERICK, MD.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>John Conrad Lerch</b>			
14. MOTHER'S MAIDEN NAME <b>Minnie Brunner</b>				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> <b>WWI</b>			
16. SOCIAL SECURITY NO. <b>705-07-6456</b>				17. INFORMANT <b>CLIN RCDS, VAH, BALTIMORE, MARYLAND</b>			
18. CAUSE OF DEATH <b>569.9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) <b>CARDIO-RESPIRATORY ARREST</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>GASTRO-INTESTINAL BLEEDING</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>							
19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <b>II</b>							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that <b>XX</b> (this hospital) attended the deceased from <b>January 20, 1972</b> to <b>January 23, 1972</b> , that <b>XX</b> (we) last saw the deceased alive on <b>January 23, 1972</b> and that in <b>our</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(X)</b> (We) (did) <b>XXXXXX</b> view the body after death.							
23A. SIGNATURE <b>Barbara A. Bergmann M.D.</b> DEGREE				23B. DATE SIGNED <b>1/23/72</b>		23C. PHYSICIAN'S NAME (Type) <b>BARBARA A. BERGMANN M.D.</b> DEGREE	
23D. ADDRESS <b>VA HOSPITAL, BALTIMORE, MARYLAND</b>				24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>			
24B. DATE <b>1/26/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>London Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>	
25B. NAME OF REGISTRAR <b>Edw. S. MacNabb Sons, Inc.</b>		25C. FUNERAL DIRECTOR ADDRESS <b>301 Frederick Rd. Catonsville, Md.</b>					

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D. C. 20535  
MEMORANDUM FOR THE DIRECTOR  
SUBJECT: [Illegible]

[Illegible text block]

[Illegible text block]

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

F-000 72 00852		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00852	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) ROWE, HELEN JANE		2. DATE AND HOUR OF DEATH JANUARY 23, 1972 9:51A. M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE MARYLAND B. COUNTY BALTIMORE		5. STREET AND NUMBER 2920 PENNSYLVANIA AVE.	
FULL NAME OF HOSPITAL OR INSTITUTION 40 ST. AGNES HOSPITAL		C. CITY OR TOWN BALTIMORE		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX FEMALE		6. RACE CAUCASIAN		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 04 25 85		9. AGE (In years last birthday) 86		10. UNDER 1 Yr. Months Days If Under 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME GEORGE SCHAD		14. MOTHER'S MAIDEN NAME FRANCES (ARNOLD)	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO		16. SOCIAL SECURITY NO. 214189971		17. INFORMANT WILKENS AVES. BALTO. MD. ST. AGNES HOSPITAL RECORDS-CATON & 21229	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ACUTE RENAL FAILURE, PULMONARY INFARCTION, MYOCARDIAL INFARCTION ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). ASCVD.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: ACUTE NECROTIZING PANCREATITIS (B) DUE TO, OR AS A CONSEQUENCE OF: ACUTE GALL STONE CHOLECYSTITIS (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 7 days 9 days 13.	
19A. DATE OF OPERATION JAN 16, 1971		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED ACUTE CHOLECYSTITIS		20A. AUTOPSY? (Yes or No) NO	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinite medical examined)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)		21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?		22. I certify that (X) (this hospital) attended the deceased from JANUARY 15 19 72 to JANUARY 23 19 72 that (X) (we) last saw the deceased alive on JANUARY 23 19 72 and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death.		23A. SIGNATURE [Signature] 23B. DATE SIGNED Jan 23, 1972	
23C. PHYSICIAN'S NAME (Type) SUNTHORN MALAISIE MD		23D. ADDRESS CATON & WILKENS AVES. BALTO., MD. 21229		23E. MED. DIRECTOR [Signature]	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial		24B. DATE 1/26/72		24C. NAME of CEMETERY or CREMATORY Loudon Park Cem.	
24D. LOCATION (City, town, or county) (State) Baltimore, Md.		25A. DATE REC'D BY HEALTH DEPT. JAN 26 1972		25B. NAME OF REGISTRAR [Signature]	
25C. FUNERAL DIRECTOR Edw. S. MacNabb Sons, Inc.		25D. ADDRESS 301 Frederick Ave. Catonsville, Md.		25E. MED. DIRECTOR [Signature]	

1951

1951

1951

1951

1951

1951

X

1951

1951

1951

1951

X

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

1951

X

1951

X

1951

X

X

X

X

1951

1951

1951

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>BERNARD DIGGS</b>				2. DATE OF DEATH Known <input checked="" type="checkbox"/> Month Day Year Estimated <input type="checkbox"/> <b>January 19, 1972</b> 10:10 P.M.			
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION <b>476 LUTHERAN HOSPITAL</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>January 19, 1972</b> 10:10 P.M.			
6. SEX <b>Male</b>				7. RACE <b>Negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>3/21/40</b>				10. AGE (In years last birthday) <b>32</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>				13. FATHER'S NAME <b>Charles Diggs</b>			
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				14B. KIND OF BUSINESS OR INDUSTRY			
15. MOTHER'S MAIDEN NAME <b>Thelma</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)			
17. SOCIAL SECURITY NO. <b>216-36-5864</b>				18. INFORMANT ADDRESS <b>Mrs Diggs,</b>			
19. <b>E880X</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).				CAUSE OF DEATH (A) IMMEDIATE CAUSE <b>Cerebro-cranial injuries</b> DUE TO, OR AS A CONSEQUENCE OF:  (B) _____ DUE TO, OR AS A CONSEQUENCE OF:  (C) _____			
20A. DATE OF OPERATION <b>2</b>				20B. CONDITION FOR WHICH OPERATION WAS PERFORMED			
21. AUTOPSY? (Yes or No) <b>Yes</b>							
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>House</b>			
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? <b>1700 W. Lafayette Avenue</b>				22D. TIME (Month) (Day) (Year) (Hour) (Minute) OF INJURY (APPROX.) <b>12-10-71 9:30 A.</b>			
22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				22F. HOW DID INJURY OCCUR? <b>Apparently accidentally fell off fire escape</b>			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Charles S. Springate</b> M.D. EXAMINER'S NAME (Type) <b>Charles S. Springate, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>January 20, 1972</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE <b>1/25/72</b>			
24C. NAME of CEMETERY or CREMATORY <b>Mt Calvary Cemetery</b>				24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>				25B. NAME OF REGISTRAR <b>Robert E. Taylor, M.D.</b>			
25C. FUNERAL DIRECTOR <b>A Halstead</b>				ADDRESS <b>1206 W North Ave</b>			

1. The first part of the report is a general description of the project. It includes the title, the objectives, the scope, and the organization of the project. The title is "The Effect of Temperature on the Rate of Reaction of Hydrogen Peroxide with Potassium Iodide". The objectives are to determine the effect of temperature on the rate of reaction and to determine the activation energy of the reaction. The scope is limited to the reaction of hydrogen peroxide with potassium iodide in aqueous solution. The organization of the project is as follows: a general description of the project, a description of the experimental procedure, a description of the results, and a conclusion.

2. The second part of the report is a description of the experimental procedure. It includes the materials, the apparatus, and the procedure. The materials are hydrogen peroxide, potassium iodide, and sulfuric acid. The apparatus is a reaction flask, a thermometer, and a stopwatch. The procedure is as follows: a known volume of hydrogen peroxide is added to a known volume of potassium iodide in a reaction flask. The temperature of the reaction mixture is measured. The time taken for the reaction to occur is measured. The rate of reaction is determined from the time taken for the reaction to occur.

3. The third part of the report is a description of the results. It includes the data, the graphs, and the calculations. The data is as follows:

Temperature (°C)	Time (s)
10	120
20	60
30	30
40	15
50	8

The graphs are as follows:

The calculations are as follows:

The activation energy (E<sub>a</sub>) is determined from the slope of the line of best fit. The slope is -1.5 x 10<sup>4</sup> K. The activation energy is 1.5 x 10<sup>4</sup> K x 8.314 J K<sup>-1</sup> mol<sup>-1</sup> = 1.25 x 10<sup>5</sup> J mol<sup>-1</sup>.

4. The fourth part of the report is a conclusion. It includes the summary of the results and the conclusions. The summary of the results is that the rate of reaction increases with increasing temperature. The conclusions are that the activation energy of the reaction is 1.25 x 10<sup>5</sup> J mol<sup>-1</sup> and that the reaction is first order with respect to hydrogen peroxide and first order with respect to potassium iodide.



W-200

72 00854

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00854

REG. NO.

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>VIRGIL WISE</b>		2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Between 622 and 624 Baker St.</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 23 1972 9:12p</b> M.	
6. SEX <b>M</b> 7. RACE <b>N</b> <b>negro male</b>		5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1402</b>	
8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
9. DATE OF BIRTH <b>1959</b>		10. AGE (In years lost birthday) <b>22</b> If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.	
11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Virgil Wise</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>	
15. MOTHER'S MAIDEN NAME <b>Juanita</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT ADDRESS <b>Mrs Sadie Hayman, same</b>	
19. <b>304.9</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.) <b>Intravenous narcotism</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20. ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-24-72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/29/72</b>	
24C. NAME of CEMETERY or CREMATORY <b>MT Calvary Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>A A County Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>A Halsead</b>		ADDRESS <b>1206 W North Ave</b>	

12800 57

STATE OF

INVESTIGATION

REPORT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <u>72 00855</u>	
BIRTH NO. <u>W-236</u> <u>72 00855</u>		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <u>Wachter, Emma</u>		2. DATE AND HOUR OF DEATH <u>Jan. 26/1972</u> <u>4:50</u> (A.M.)	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
FULL NAME OF HOSPITAL OR INSTITUTION <u>Baltimore City Hospitals</u> <u>4940 Eastern Avenue</u> <u>Baltimore, Maryland 21224</u>		A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u> 6. RACE <u>Caucasian</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/23/97</u> 9. AGE (In years last birthday) <u>74</u>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Lewis Hammelmann</u>		14. MOTHER'S MAIDEN NAME <u>Margaret</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Records: BCH-4940 Eastern Ave. Baltimore, Maryland</u>		ADDRESS <u>21224</u>	
18. <u>250,71</u> CAUSE OF DEATH		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Acute myocardial infarction</u>	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(B) DUE TO, OR AS A CONSEQUENCE OF: <u>Atherosclerotic cardiac - vascular disease</u>	
(C) <u>Diabetes mellitus</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		<u>CVA - (R) hemisphere</u>	
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20A. AUTOPSY? (Yes or No) <u>No</u>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from <u>Jan. 24 1972</u> to <u>Jan. 26 1972</u> that (1) (we) last saw the deceased alive on <u>Jan. 26 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <u>Jay E. McEntoug, MD</u>		23B. DATE SIGNED <u>1/26/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>Jay E. McEntoug, MD</u>		23D. ADDRESS <u>Balt. City Hosp., Balt. Md 21224</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-28-1972</u>	
24C. NAME of CEMETERY or CREMATORY <u>Holy Redeemer</u>		24D. LOCATION (City, town, or county) (State) <u>Baltimore, Maryland</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1972</u>		25B. NAME OF REGISTRAR <u>Robert E. Seiber, R.D.</u>	
25C. FUNERAL DIRECTOR <u>Lilly &amp; Zeiler Inc.</u>		ADDRESS <u>1901-07 Eastern Ave.</u>	

2000

1000

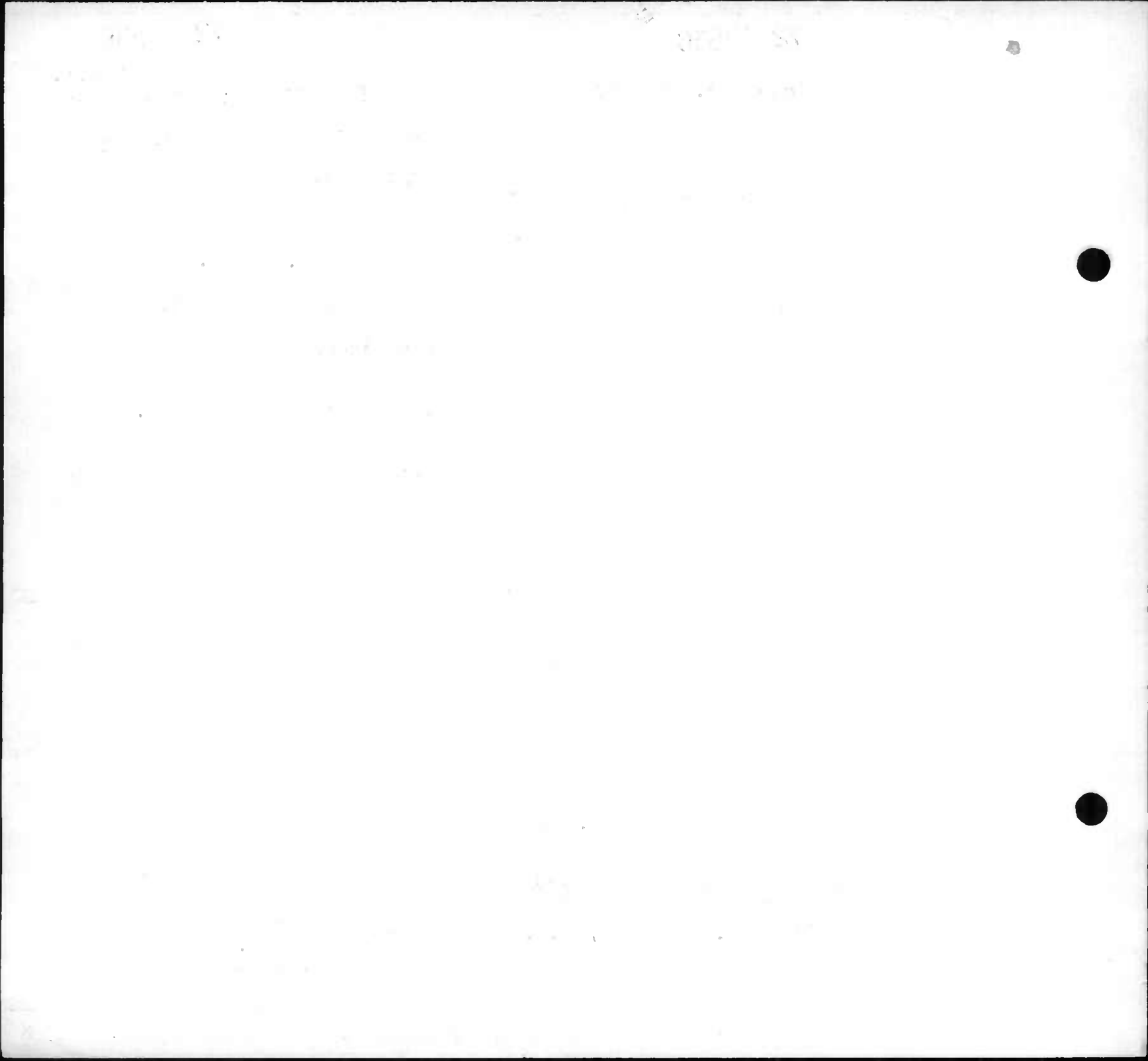
Blank page  
No text

Blank page  
No text

Blank page  
No text

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <u>S-315 Conn.</u> <u>72 00856</u>		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. <u>72 00856</u>	
1. NAME OF DECEASED (Type or Print) <u>Michael A. Stevens</u>			2. DATE AND HOUR OF DEATH <u>10 A.M.</u> <u>1/21/72 at approximately</u> M.		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <u>31 Baltimore City Hospital</u>			4. USUAL RESIDENCE (Where deceased lived. If institution residence before admission) A. STATE <u>Maryland</u> B. COUNTY <u>2605</u>		
			C. CITY OR TOWN <u>Baltimore</u>		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <u>400 Imla Street</u>		
5. SEX <u>M</u>	6. RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/3/70</u>	9. AGE (In years last birthday) <u>1 yr. 6 Mos.</u>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10B. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>
13. FATHER'S NAME <u>Nicholas Stevens</u>			14. MOTHER'S MAIDEN NAME <u>Lola Adams</u>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service] <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>	17. INFORMANT <u>Steven Martin</u> ADDRESS <u>400 Imla St.</u>		
18. <u>470X I</u> CAUSE OF DEATH					
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>Influenza</u> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Antecedent causes</u> (B) DUE TO, OR AS A CONSEQUENCE OF: <u>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</u> (C) _____					
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>0</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>June 1 1971</u> 19 <u>Jan 20</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>Jan. 20</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (not) view the body after death.					
23A. SIGNATURE <u>William E. Schwartz</u>				23B. DATE SIGNED <u>1/21/72</u>	
23C. PHYSICIAN'S NAME (Type) <u>William E. Schwartz, M.D.</u>				23D. ADDRESS <u>7112 Darlington Drive</u> <u>Baltimore Md. 21244</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1/27/72</u>		24C. NAME of CEMETERY or CREMATORY <u>Florida</u>	
24D. LOCATION <u>Miami, Florida</u>		(City, town, or county) (State)			
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1972</u>		25B. NAME OF REGISTRAR <u>Robert J. ...</u>		25C. FUNERAL DIRECTOR <u>James M. ...</u>	
ADDRESS <u>322 S. ...</u>					



P-000

72 00857 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00857

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Lee Po / LEE POO

2. DATE OF DEATH Known ☒ Estimated ☐ Month Day Year Hour  
1 24 72 11:52A M.4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

210 W. Pleasant Street

3. DATE PRONOUNCED DEAD Month Day Year Hour  
1 24 72 11:52A M.

5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)

A. STATE Maryland B. COUNTY 401

6. SEX

Male

7. RACE

Yellow

8. MARRIED ☒ NEVER MARRIED ☐WIDOWED ☐ DIVORCED ☐

C. CITY OR TOWN

Baltimore

D. INSIDE CITY LIMITS?

YES ☒ NO ☐

9. DATE OF BIRTH

Dec. 11, 1895

10. AGE (In years last birthday)

76

11. Under 1 Yr. 11 Under 24 Hrs. Months Days Hours Min.

E. STREET AND NUMBER

210 W. Pleasant Street

11. BIRTHPLACE (State or foreign country)

China

12. CITIZEN OF WHAT COUNTRY?

Unknown

13. FATHER'S NAME

Unknown

14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Retired

14B. KIND OF BUSINESS OR INDUSTRY

?

15. MOTHER'S MAIDEN NAME

16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)

No

17. SOCIAL SECURITY NO. A

216-34-7738

18. INFORMANT Friend:

ADDRESS

Mr. Calvin Chin 323 Park Ave. 21201

19.

CAUSE OF DEATH

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease  
DUE TO, OR AS A CONSEQUENCE OF:ANTECEDENT CAUSES  
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.(B) DUE TO, OR AS A CONSEQUENCE OF:  
(C)II  
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

20A. DATE OF OPERATION

20B. CONDITION FOR WHICH OPERATION WAS PERFORMED

21. AUTOPSY? (Yes or No)

No

22A. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.

22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?

22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

22E. INJURY OCCURRED

WHILE AT WORK ☐ NOT WHILE AT WORK ☐

22F. HOW DID INJURY OCCUR?

23.

I certify that I held on Inquiry ☐ Inspection ☒ Autopsy ☐ and that on this basis, death in my opinion resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL SIGNATURE  
EXAMINER'S NAME (Type)

Werner U. Spitz, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☒  
ASSISTANT MEDICAL EXAMINER ☐  
ASSOCIATE MEDICAL EXAMINER ☐

DATE SIGNED

1-25-72

24A. BURIAL CREMATION, REMOVAL (Specify)

Burial

24B. DATE

1/26/72

24C. NAME of CEMETERY or CREMATORY

Lorraine Park Cemetery

24D. LOCATION (City, town, or county) (State)

Woodlawn, Balto. Co., Md.

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1972

25B. NAME OF REGISTRAR

Robert E. Jaber, M.D.

25C. FUNERAL DIRECTOR

ADDRESS

STEWART &amp; MOWEN CO. 108 W. North Ave (1)

1925

1925

1925

1925

1925

1925

1925

1925

1925

1925

1925

1925

1925

1925

1925

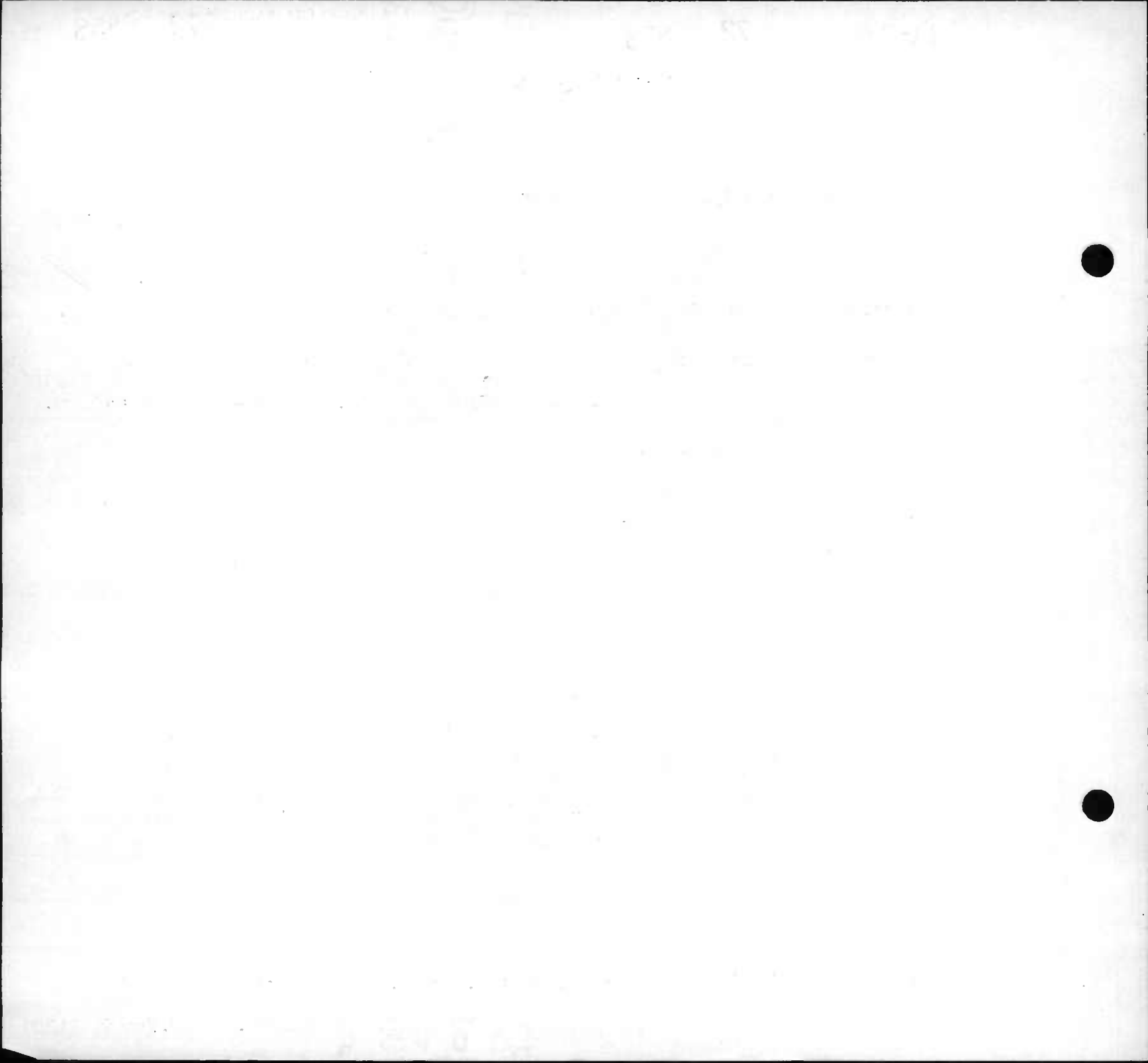
1925



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

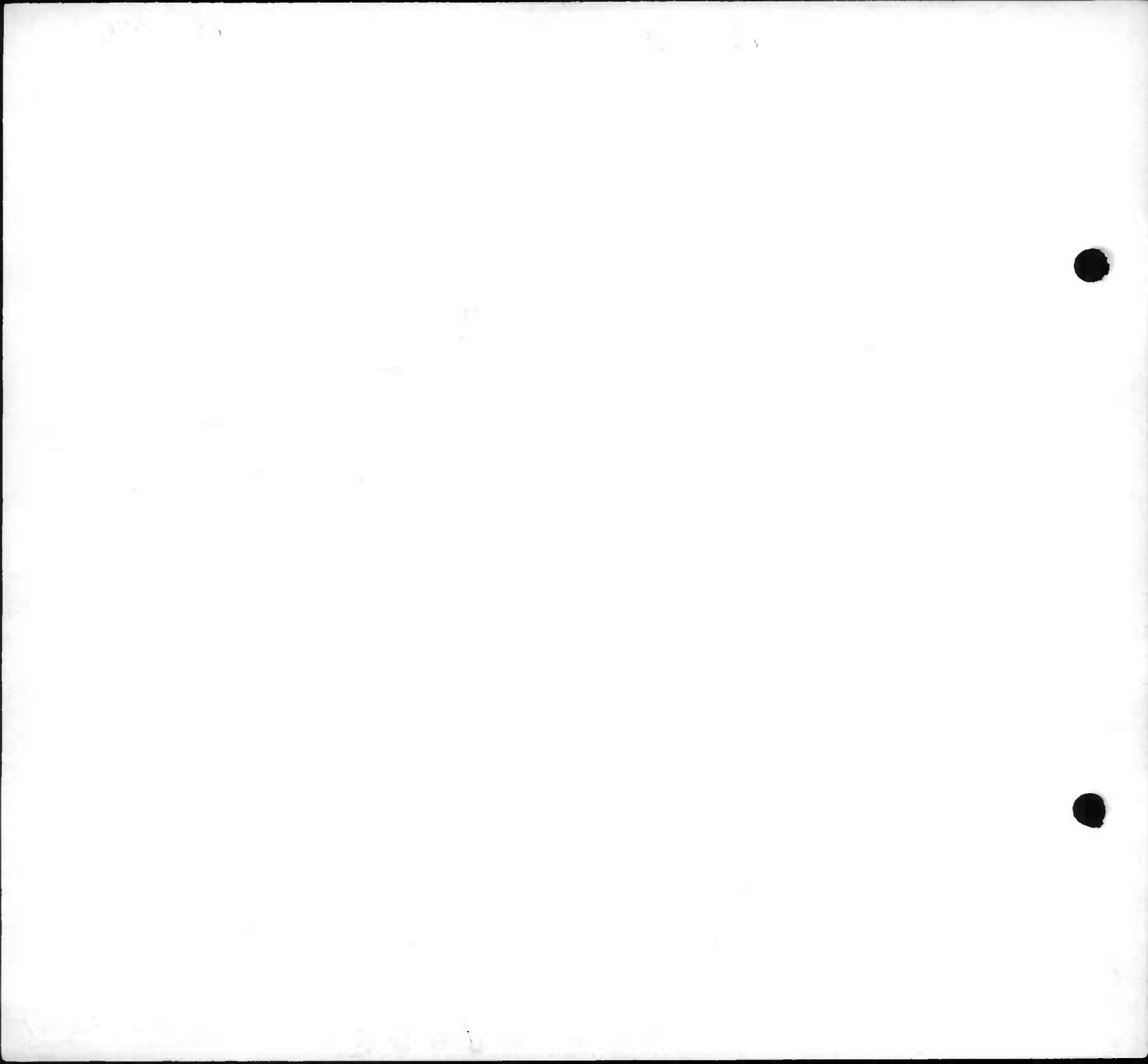
<p><b>D-320</b>      <b>72 00858</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p>		<p>REG. NO. <b>72 00858</b></p>	
<p><b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>LOUISA (NMN) DOETSCH</b></p>		<p><b>2. DATE AND HOUR OF DEATH</b> <b>Jan 25, 1972</b>      <b>6<sup>30</sup> A.M.</b></p>	
<p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p> <p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b>      B. COUNTY <b>2714</b></p>		<p><b>5. CITY OR TOWN</b> <b>Baltimore</b>      <b>D. INSIDE CITY LIMITS?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>	
<p><b>6. STREET AND NUMBER</b> <b>4401 Roland Avenue</b></p>		<p><b>7. AGE</b> (In years last birthday) <b>84</b>      <b>8. DATE OF BIRTH</b> <b>Nov. 5, 1887</b></p>	
<p><b>9. SEX</b> <b>Female</b>      <b>10. RACE</b> <b>White</b>      <b>11. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input checked="" type="checkbox"/>      <b>12. WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p>		<p><b>13. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Retired-Librarian</b>      <b>14. KIND OF BUSINESS OR INDUSTRY</b> <b>Newspaper</b></p>	
<p><b>15. FATHER'S NAME</b> <b>Louis John Doetsch</b></p>		<p><b>16. MOTHER'S MAIDEN NAME</b> <b>Johanna Pohl</b></p>	
<p><b>17. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b></p>		<p><b>18. SOCIAL SECURITY NO.</b> <b>212-10-8411</b>      <b>19. INFORMANT:</b> <b>sister</b>      <b>ADDRESS</b> <b>21210</b></p>	
<p><b>20. Miss Agnes J. Doetsch-4401 Roland Av.</b></p>		<p><b>21. BIRTHPLACE</b> (State or foreign country) <b>Baltimore, Maryland</b>      <b>22. CITIZEN OF WHAT COUNTRY?</b> <b>USA</b></p>	
<p><b>18. CAUSE OF DEATH</b></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.) <b>Metastatic Carcinoma of Breast</b></p> <p><b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) DUE TO, OR AS A CONSEQUENCE OF:</p>			
<p><b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b></p>			
<p><b>19A. DATE OF OPERATION</b> <b>174X</b>      <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>		<p><b>20A. AUTOPSY?</b> (Yes or No) <b>no</b>      <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>	
<p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/></p>		<p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>	
<p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>		<p><b>21D. TIME OF INJURY</b> (Approx.) (Month) (Day) (Year) (Hour)</p>	
<p><b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>		<p><b>21F. HOW DID INJURY OCCUR?</b></p>	
<p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <b>19 50</b> <b>to</b> <b>Jan 25, 1972</b>, <b>that (I) (we) last saw the deceased alive on</b> <b>Jan 24, 1972</b> <b>and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>			
<p><b>23A. SIGNATURE</b> <b>Walter B. Buck</b></p>		<p><b>23B. DATE SIGNED</b> <b>Jan 25, 72</b></p>	
<p><b>23C. PHYSICIAN'S NAME</b> (Type) <b>WALTER B. BUCK</b></p>		<p><b>23D. ADDRESS</b> <b>15 E BIDDLE 21202</b></p>	
<p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <b>CREMATION</b></p>		<p><b>24B. DATE</b> <b>1/25/72</b>      <b>24C. NAME OF CEMETERY OR CREMATORY</b> <b>Green Mount Cem. Crem.</b></p>	
<p><b>24D. LOCATION</b> (City, town, or county) (State) <b>Baltimore, Maryland</b></p>		<p><b>25A. DATE REC'D BY HEALTH DEPT.</b> <b>JAN 26 1972</b>      <b>25B. NAME OF REGISTRAR</b> <b>STEWART &amp; MOWEN CO.</b></p>	
<p><b>25C. FUNERAL DIRECTOR</b> <b>STEWART &amp; MOWEN CO.</b></p>		<p><b>25D. ADDRESS</b> <b>108 W. North 21201</b></p>	



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

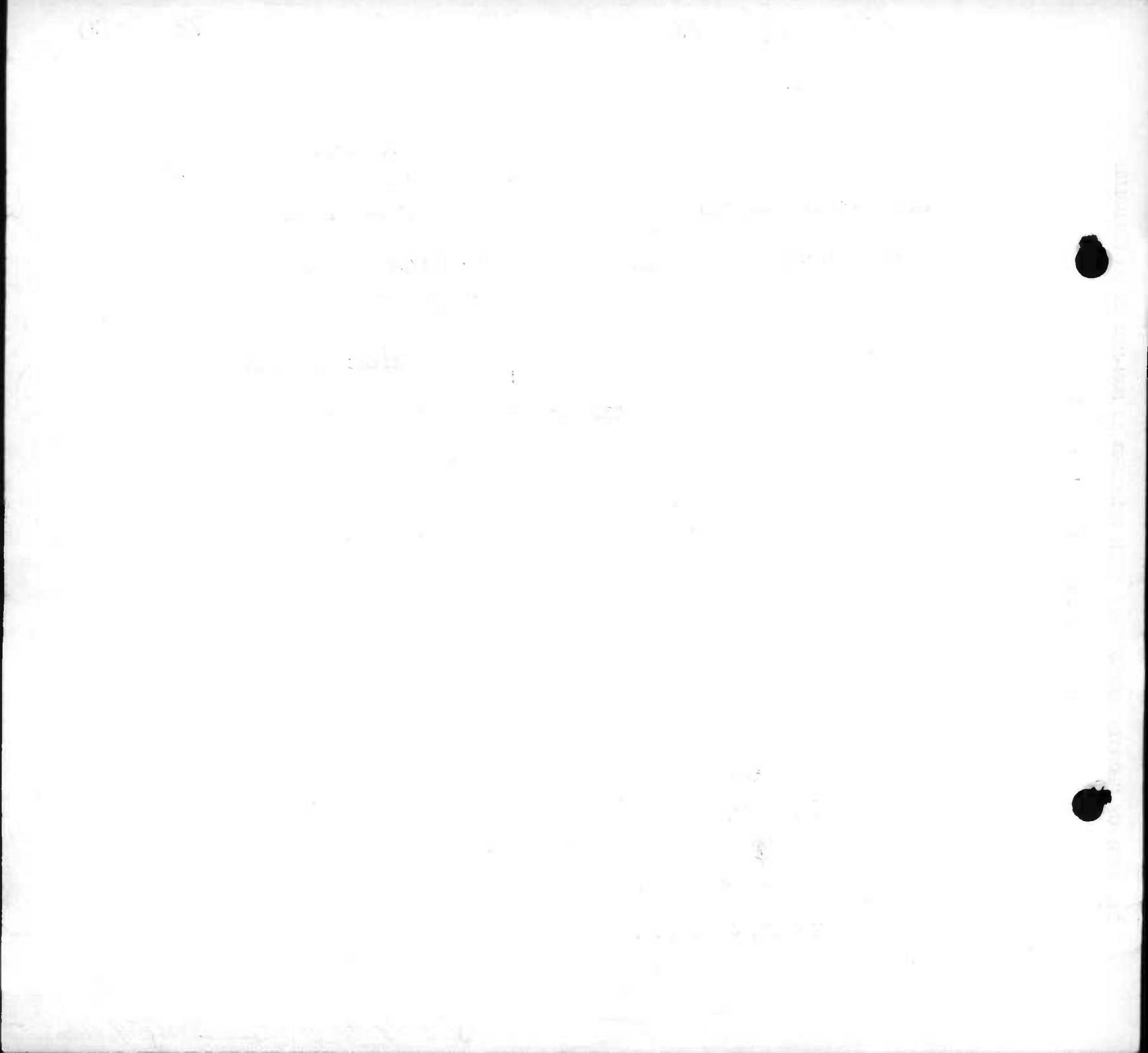
J-520		72 00859		BALTIMORE CITY HEALTH DEPARTMENT		72 00859	
BIRTH NO.		72 00859		CERTIFICATE OF DEATH		REG. NO.	
1. NAME OF DECEASED (Type or Print) <i>Lucy Jones</i>				2. DATE AND HOUR OF DEATH <i>1-23-72</i> <i>5:00 P.M.</i>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>BOLTON HILL NURSING HOME</i>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <i>MARYLAND</i> B. COUNTY <i>2301</i> C. CITY OR TOWN <i>BALTIMORE</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>913 LEADEN HALL</i>			
5. SEX <i>Female</i>	6. RACE <i>BLACK</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-6-06</i>	9. AGE (In years last birthday) <i>65 yrs</i>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Se</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Cannery</i>		11. BIRTHPLACE (State or foreign country) <i>ny</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Arty Ellis</i>				14. MOTHER'S MAIDEN NAME <i>Ortate Willey</i>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Admission Record</i>		ADDRESS	
18. I <i>184.1 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <i>This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.</i> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <i>C.A. Vibration</i> <i>retasture</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs.</i>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <i>12/23</i> 19 <i>71</i> to <i>1/23</i> 19 <i>72</i> that (I) (we) last saw the deceased alive on <i>1/23</i> 19 <i>72</i> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <i>a</i>				23B. DATE SIGNED <i>1/24/72</i>			
23C. PHYSICIAN'S NAME (Type) <i>ALAN H. MARCH MD</i>				23D. ADDRESS <i>26 Real St Baltimore</i>			
24A. BURIAL, CREMATION, REMOVAL (Specify)		24B. DATE <i>1/27/72</i>		24C. NAME of CEMETERY or CREMATORY <i>Int Churum</i>		24D. LOCATION (City, town, or county) (State) <i>Balto City</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1972</i>		25B. NAME OF REGISTRAR <i>W. E. H. H. H.</i>		25C. FUNERAL DIRECTOR <i>J. L. BROWN</i>		ADDRESS <i>123 W MONTGOMERY CYST</i>	



## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

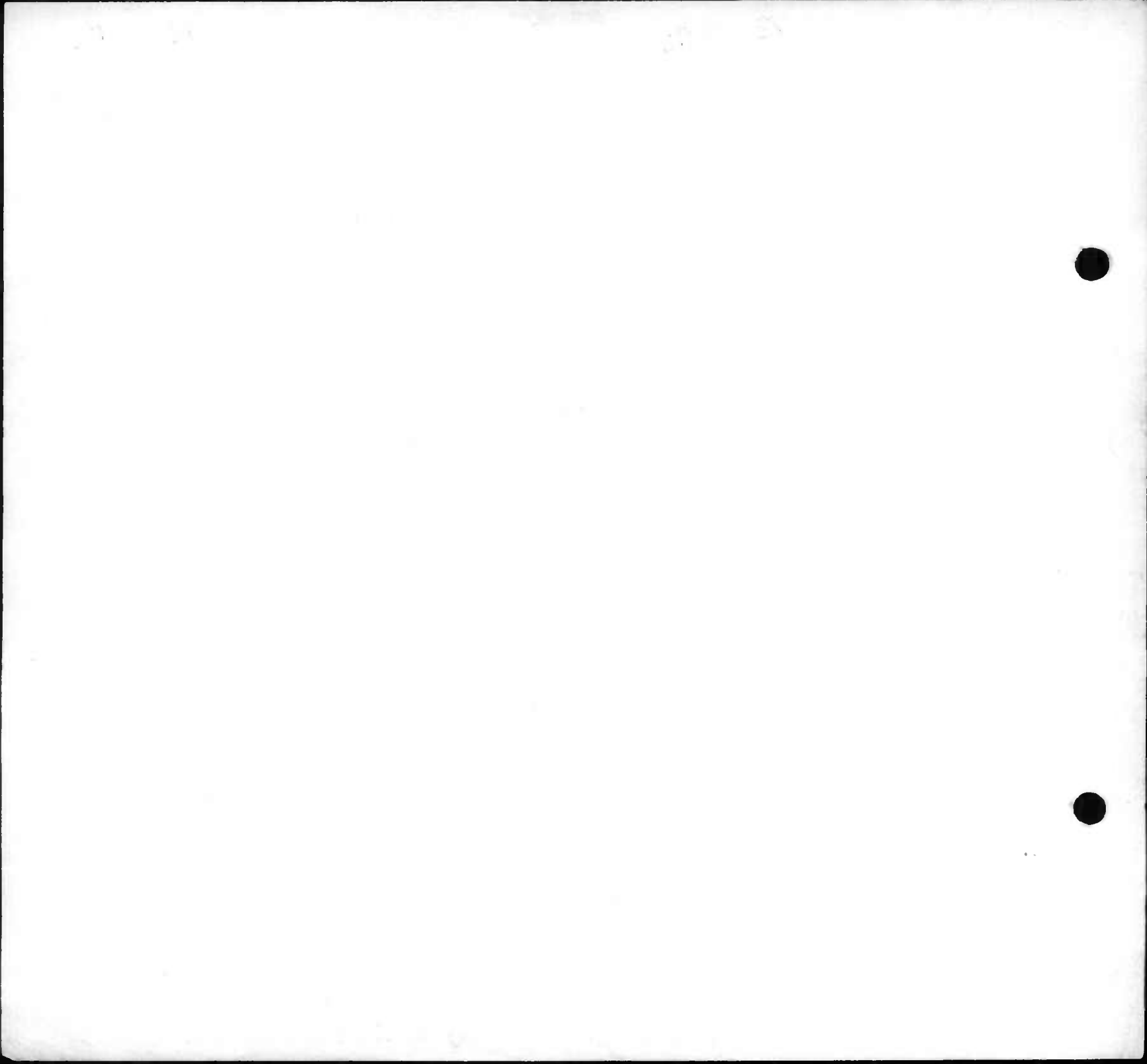
BIRTH NO. <b>W-252</b>		72 00860		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <b>72 00860</b>	
1. NAME OF DECEASED (Type or Print) <b>GEORGIA WIGGINS</b>				2. DATE AND HOUR OF DEATH <b>1-22-72</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>33 JOHNS HOPKINS HOSPITAL</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>603</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2118 ORLEANS ST</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>09/21/04</b>	9. AGE (in years last birthday) <b>65</b>	10. Under 1 Yr. Months Days 11. Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10B. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore Md</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>John Thomas</b>				14. MOTHER'S MAIDEN NAME <b>SPENCER, ELSIE</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>223 14 0834</b>		17. INFORMANT <b>Nathaniel Spencer 100 Mt Vernon Ave</b>		ADDRESS <b>Md</b>	
18. <b>254X1</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Pneumonia</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Asplastic Anemia</b>				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Pneumonia</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>Asplastic Anemia</b> (C) _____			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <b>NO</b>		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from <b>1-18</b> 19 <b>72</b> to <b>1-22</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1-22</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE <b>James F. Martin</b>				Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>		23B. DATE SIGNED <b>1-22-72</b>	
23C. PHYSICIAN'S NAME (Type) <b>MARTIN, JAMES M.D.</b>				23D. ADDRESS			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-26-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt Calvary Cent</b>		24D. LOCATION (City, town, or county) (State) <b>AA County Md</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>		25B. NAME OF REGISTRAR <b>Robert J. Taylor</b>		25C. FUNERAL DIRECTOR <b>Edw. J. Taylor</b> ADDRESS <b>1000 Maryland Ave</b>			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>M-320</b>		72 00861		BALTIMORE CITY HEALTH DEPARTMENT		CERTIFICATE OF DEATH		REG. NO. <b>72 00861</b>	
1. NAME OF DECEASED (Type or Print) <b>MATTHEWS, Mr. FINELY</b>				2. DATE AND HOUR OF DEATH <b>1/23/72</b> <b>11:10 A.M.</b>					
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Church Home &amp; Hospital = 5100 BROADWAY Blvd. 21231</b>				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <b>MD.</b> B. COUNTY <b>BALTIMORE</b> <b>301</b> C. CITY OR TOWN <b>City.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>15 N. CAROLINE ST. 21231</b>					
5. SEX <b>MALE</b>	6. RACE <b>NEGRO</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>07/20/09</b>	9. AGE (in years last birthday) <b>62</b>	If Under 1 Yr. Months: Days: Hours: Min.				
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>?</b>				10B. KIND OF BUSINESS OR INDUSTRY <b>&lt;</b>		11. BIRTHPLACE (State or foreign country) <b>S.C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>AMERICAN.</b>	
13. FATHER'S NAME <b>JOHN MATTHEWS.</b>				14. MOTHER'S MAIDEN NAME <b>?</b>					
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>W</b>				16. SOCIAL SECURITY NO. <b>579 096738</b>		17. INFORMANT ADDRESS			
18. <b>3 7191</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				CAUSE OF DEATH <b>Aspiration - PNEUMONIA. = SEPTICEMIA.</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>SEVERE LIVER DISEASE. probably CIRRHOSIS of the LIVER.</b> (B) DUE TO, OR AS A CONSEQUENCE OF: <b>CHRONIC OEST. LUP. SYNDROM.</b> (C) <b>A PNEUMONIA.</b> <b>RENAL FAILURE.</b>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs.</b>	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).									
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)					
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?					
22. I certify that (I) (this hospital) attended the deceased from <b>1/20/72</b> 19 to <b>1/23/72</b> 19 that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.									
23A. SIGNATURE <b>Richard V. Feldman</b>				23B. DATE SIGNED <b>1/23/72</b>		23C. PHYSICIAN'S NAME (Type) <b>DICKERICK V. FELDMAN</b>			
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE <b>1-22-72</b>		24C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary Cmt.</b>		24D. LOCATION (City, town, or county) (State) <b>Calvert County Md</b>			
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>		25B. NAME OF REGISTRAR <b>John E. Taylor, Jr.</b>		25C. FUNERAL DIRECTOR <b>Edwin Brown</b>		25D. ADDRESS <b>Brown &amp; Brown</b>			

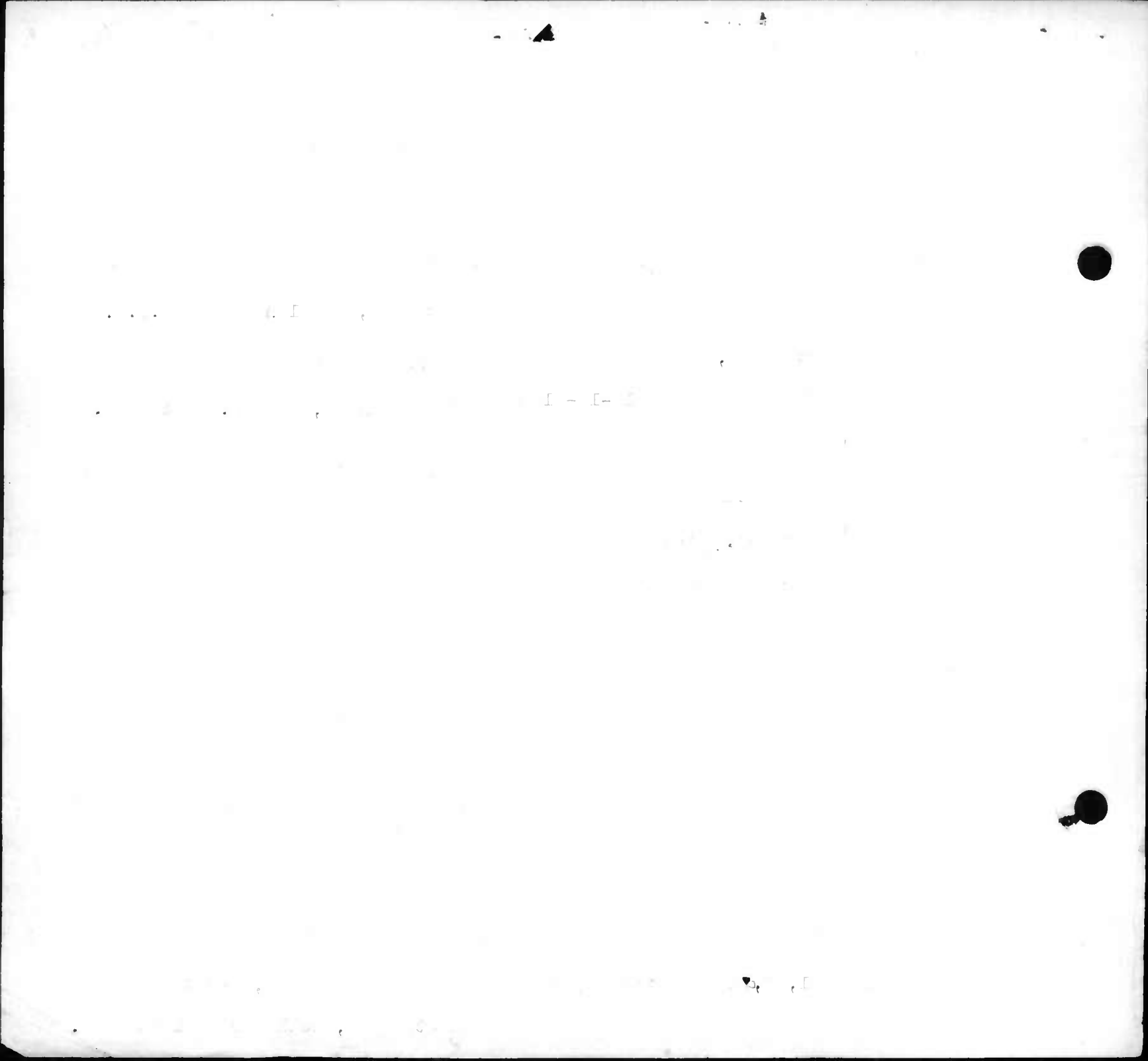




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT		72 00862		REG. NO. 72 00862	
BIRTH NO. 72 00862		<b>CERTIFICATE OF DEATH</b>			
1. NAME OF DECEASED (Type or Print) <i>Annice</i>		2. DATE AND HOUR OF DEATH <i>1-18-72</i> <i>9:15</i> M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <i>Mt. Sinai Nursing Home</i> <i>4413 Park Heights Ave</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Maryland</i> B. COUNTY <i>908</i>			
5. SEX <i>F</i>		6. RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <i>4-21-99</i>	
13. FATHER'S NAME <i>Thomas McQuade, James</i>		14. MOTHER'S MAIDEN NAME <i>Mary Boylan</i>		9. AGE (In years last birthday) <i>72</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>216-12-5190</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore, Maryland</i>	
17. INFORMANT <i>Regina Williams, 1250 E. North Ave.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		10. AGE (In years last birthday) <i>72</i>	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, pneumonia, etc., but the disease, injury or complication which caused death.) <i>ASCVD</i> <i>Fractured Pelvis - Pinned</i>		IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
ANTECEDENT CAUSES (Three or more medical conditions giving rise to the above cause, or stating the UNDERLYING CONDITION last.)		(B) DUE TO, OR AS A CONSEQUENCE OF:			
(C) DUE TO, OR AS A CONSEQUENCE OF:					
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <i>0</i>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <i>Nursing Home</i>		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <i>4613 Park Heights Ave</i>	
21D. TIME OF INJURY (APPROX.) <i>11-26-71</i>		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>		21F. HOW DID INJURY OCCUR? <i>fall</i>	
22. I certify that (I) (this hospital) attended the deceased from <i>12/17/71</i> to <i>1/18/72</i> that (I) (we) last saw the deceased alive on <i>1/18/72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <i>Edward S. Kallins MD</i>		23B. DATE SIGNED <i>1/20/72</i>		23C. PHYSICIAN'S NAME (Type) <i>Edward S. KALLINS MD</i>	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1, 25, 72</i>		24C. NAME OF CEMETERY or CREMATORY <i>Louden Park</i>	
25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1972</i>		25B. NAME OF REGISTRAR <i>E. E. Taber MD</i>		25C. FUNERAL DIRECTOR <i>Kenneth Law</i>	
24D. LOCATION (City, town, or county) <i>Baltimore, Maryland</i>		24E. ADDRESS <i>6000 PARK HHS AV Baltimore Md 21215</i>		24F. ADDRESS <i>4611 Park Heights Ave.</i>	



1  
T520

## BALTIMORE CITY HEALTH DEPARTMENT

72 00863 MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 72 00863	
1. NAME OF DECEASED (Type or Print) <b>LONITA THOMAS</b>				2. DATE OF DEATH Known <input type="checkbox"/> Month Day Year Hour Estimated <input type="checkbox"/> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>34 Bon Secours Hospital</b>				3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 17 1972 12:15a M.</b>	
5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>Md.</b> B. COUNTY <b>1603</b>				C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
6. SEX <b>female</b>		7. RACE <b>negro</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. DATE OF BIRTH <b>1/-/9/68</b>		10. AGE (In years lost birthday) <b>4</b>		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>John Thomas</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
15. MOTHER'S MAIDEN NAME <b>Brenda Ridley</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>		17. SOCIAL SECURITY NO. <b>None</b>	
18. INFORMANT <b>Louise Flood, 532 N. Gilmore St.</b>		19. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple injuries</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. <b>II</b> OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED		21. AUTOPSY? (Yes or No) <b>yes</b>	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>home</b>		22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>532 N. Gilmore St. 16-03</b>	
22D. TIME OF INJURY (APPROX.) <b>1-?-72</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		22F. HOW DID INJURY OCCUR? <b>Sustained multiple blunt impacts.</b>	
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> M.D. EXAMINER'S NAME (Type) CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-17-72</b>					
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/22/72</b>		24C. NAME OF CEMETERY or CREMATORY <b>Mt. Calvary</b>	
24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>		25B. NAME OF REGISTRAR <b>James E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Kenneth Law, 4611 Park Heights Ave.</b>		25D. ADDRESS		25E. ADDRESS	

2-23-1972 - Completion of cause of death on a pending medical examiner death certificate.

Russell S. Fisher, M.D.

HRS

X

8/21-11

8/21-11

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

72 00864		BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH		REG. NO. 72 00864	
BIRTH NO.		1. NAME OF DECEASED (Type or Print) <u>STUROIVANT, MAJOR</u>		2. DATE AND HOUR OF DEATH <u>1/23/72</u> <u>1135 A.M.</u>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <u>BALTO. MD</u> B. COUNTY <u>5</u>		C. CITY OR TOWN <u>BALTO. MD</u>	
FULL NAME OF HOSPITAL OR INSTITUTION <u>UNIVERSITY OF MD HOSPITAL</u> <u>38</u>		(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX <u>M</u>		6. RACE <u>N</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DISABILITY</u>		10B. KIND OF BUSINESS OR INDUSTRY		8. DATE OF BIRTH <u>5/6/12</u>	
13. FATHER'S NAME <u>NOYE STUROIVANT</u>		14. MOTHER'S MAIDEN NAME <u>JENNIE EVANS</u>		9. AGE (In years last birthday) <u>59</u>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>230-07-7754</u>		11. BIRTHPLACE (State or foreign country) <u>VA. BRACY</u>	
17. INFORMANT <u>CHART-Patricia Britton</u>		ADDRESS <u>205 Pelican Dr.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
18. <u>200.1 I</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>SEPTICEMIA + RESPIRATORY FAILURE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>	
(B) <u>LYMPHOSARCOMA</u> DUE TO, OR AS A CONSEQUENCE OF:		(C) <u>BRONCHIAL ASTHMA</u>		<u>3 years</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <u>2</u>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) <u>YES</u>	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <u>12/16</u> 19 <u>71</u> to <u>1/23</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/23</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <u>Lawrence A. Fleming MD</u>		23B. DATE SIGNED <u>1/23/72</u>		23C. PHYSICIAN'S NAME (Type) <u>LAWRENCE A. FLEMING MD</u>	
24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>		24B. DATE <u>1-27-72</u>		24C. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	
25A. DATE REC'D BY HEALTH DEPT. <u>JAN 26 1972</u>		25B. NAME OF REGISTRAR <u>R. E. Spiller, MD</u>		25C. FUNERAL DIRECTOR <u>W. D. Dyer, F.H.</u>	
25D. ADDRESS <u>UNIVERSITY OF MD HOSP.</u>		25E. ADDRESS <u>1701-hauvens St.</u>		25F. ADDRESS	

1998-1999

1  
S 530

## BALTIMORE CITY HEALTH DEPARTMENT

72 00865 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00865

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Avis Marie Smith</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month Day Year Hour <b>1 20 72</b> M.	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>44 Union Memorial Hospital</b>		3. DATE PRONOUNCED DEAD Month Day Year Hour <b>1 20 72 7:35 p.m.</b>	
6. SEX <b>female</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7. RACE <b>Negro</b>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>10-12-04 67</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
10. AGE (In years last birthday) <b>67</b>		E. STREET AND NUMBER <b>2517 Linden Avenue</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		15. MOTHER'S MAIDEN NAME <b>Beatrice Williams</b>	
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)		17. SOCIAL SECURITY NO. <b>219-30-9154</b>	
18. INFORMANT <b>Beverly Davenport</b>		ADDRESS <b>3919 Oakford Ave.</b>	
19. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>Multiple injuries</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>STREET</b>	
22D. TIME OF INJURY (APPROX.) Month Day Year Hour <b>1 20 y 72 7:25 p.m.</b>		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	
22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <b>3000 block of N. Charles St.</b>		22F. HOW DID INJURY OCCUR? <b>Subject pedestrian hit by car while crossing street.</b>	
23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Peter Lipkovic</b> EXAMINER'S NAME (Type)		DATE SIGNED <b>1/21/72</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1/25/72</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Mt. Cereary</b>		24D. LOCATION (City, town, or county) (State) <b>A.A. Co. Md.</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Fisher, M.D.</b>	
25C. FUNERAL DIRECTOR <b>Wilmington</b>		ADDRESS <b>1727 N. Meade St.</b>	

682-10-31

82

1968-10-31

1968-10-31

1968-10-31

1968-10-31

1968-10-31

1968-10-31

1968-10-31

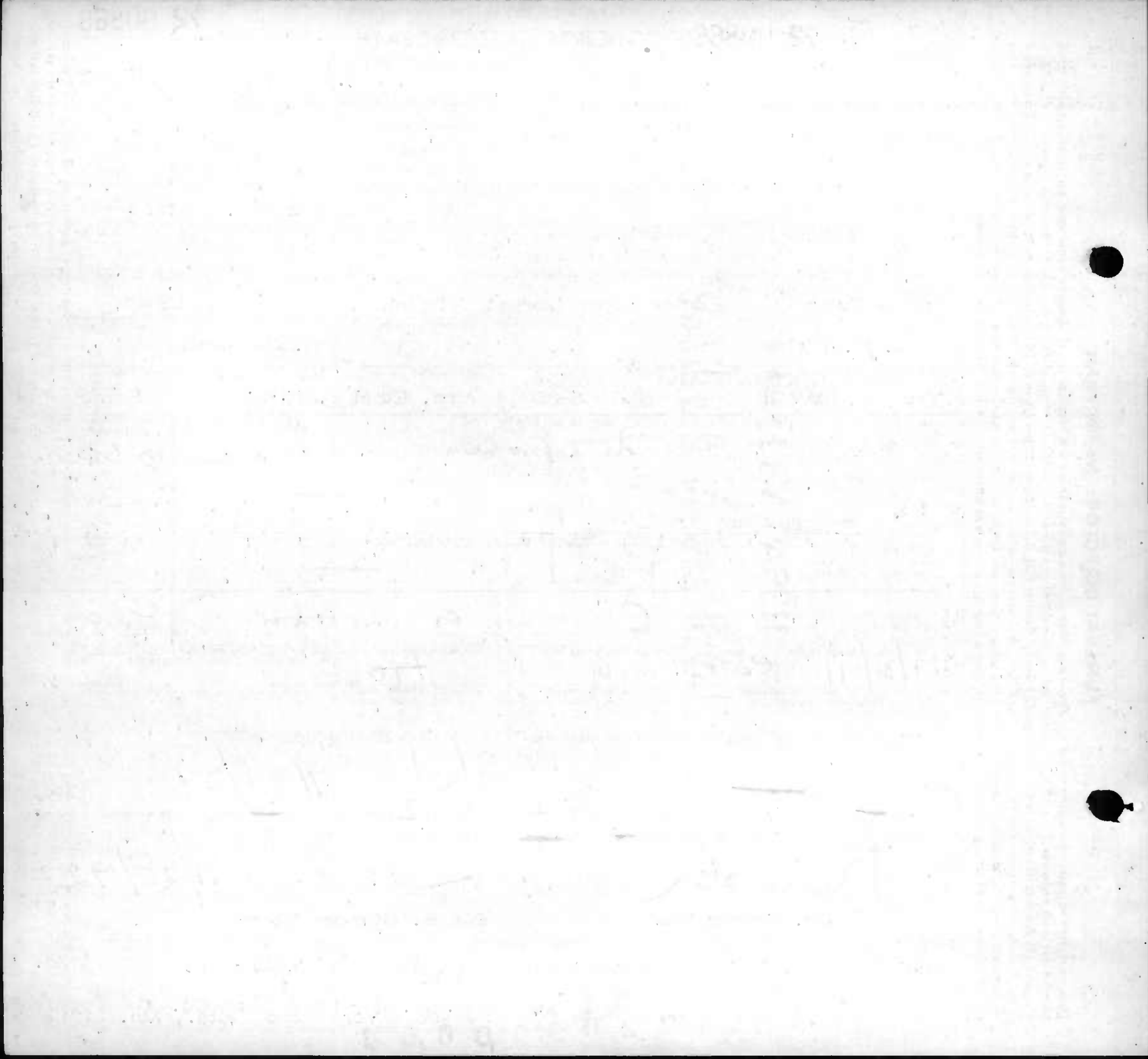
1968-10-31



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

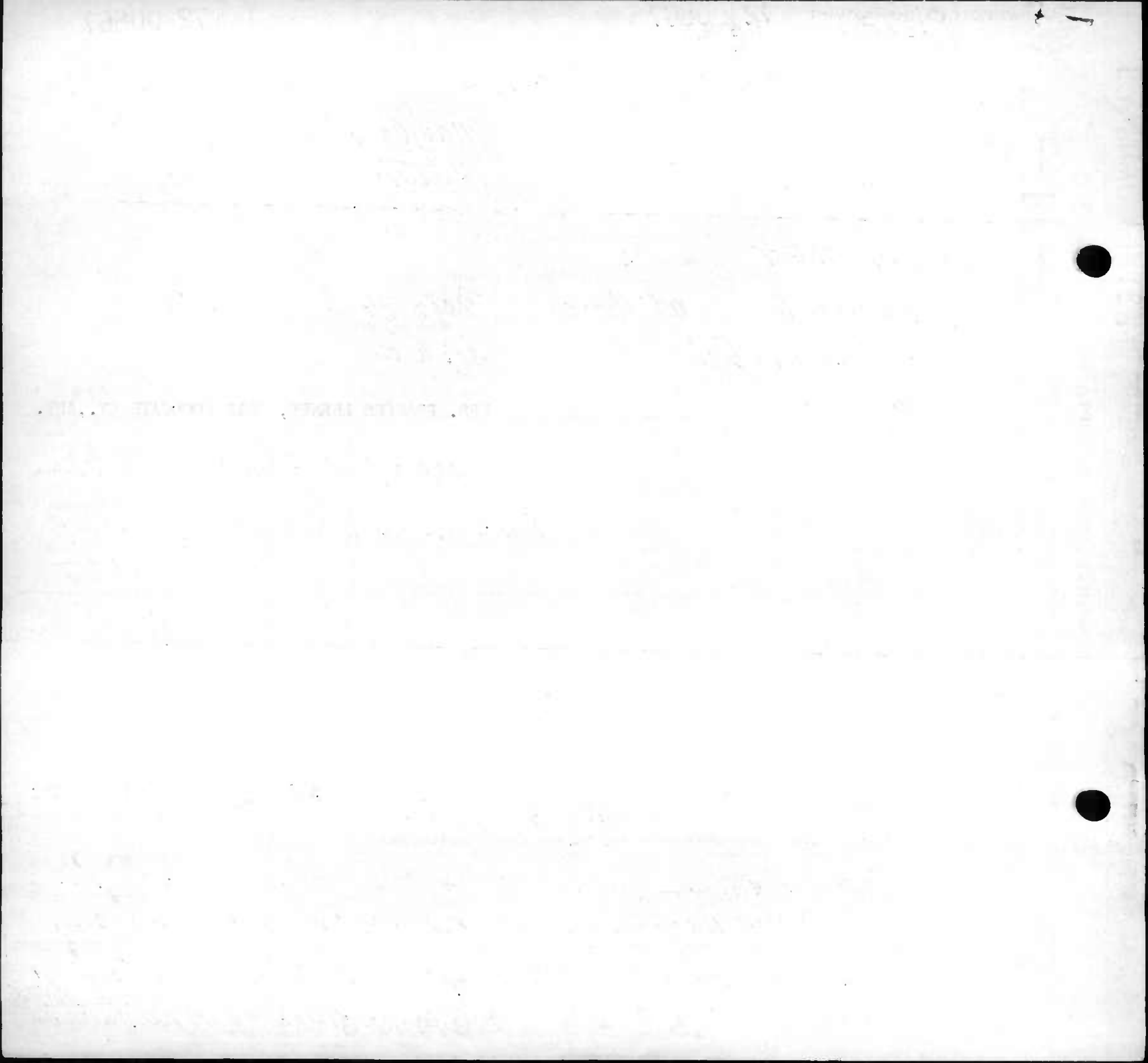
BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="font-size: 1.2em;">72 00866</span>	
<div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">F-432</span> <span style="font-size: 1.5em;">72 00866</span> <span style="font-size: 1.5em;">72 00866</span> </div>					
BIRTH NO. <span style="float: right;">1</span>					
1. NAME OF DECEASED (Type or Print) <span style="font-size: 1.2em;">Roy H. Fields</span>			2. DATE AND HOUR OF DEATH <span style="font-size: 1.2em;">Jan. 24, 1972</span> <span style="float: right;"><span style="font-size: 1.5em;">10:00 P</span> M.</span>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  <span style="font-size: 1.2em;">3635 Old York Road</span>			4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE <span style="font-size: 1.2em;">Maryland</span> <span style="float: right;"><span style="font-size: 1.5em;">901</span></span> B. COUNTY  C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  E. STREET AND NUMBER <span style="font-size: 1.2em;">3809 Greenmount Ave. 21218</span>		
5. SEX <span style="font-size: 1.2em;">M</span>	6. RACE <span style="font-size: 1.2em;">W</span>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <span style="font-size: 1.2em;">3-5-1916</span>	9. AGE (In years last birthday) <span style="font-size: 1.2em;">55</span>	If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">Meat Cutter</span>			10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Eddies Super Market</span>		11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">Virginia</span>
12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">USA</span>			13. FATHER'S NAME <span style="font-size: 1.2em;">J. D. Fields</span>		
14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">D. Campbell</span>			15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">Yes WW II</span>		
16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">227-03-3508</span>			17. INFORMANT <span style="font-size: 1.2em;">Mrs. Ethel J. Fields</span>		
18. ADDRESS <span style="font-size: 1.2em;">Same</span>			19. CAUSE OF DEATH <span style="font-size: 1.5em;">Colon Adenocarcinoma of</span>		
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)  ANTECEDENT CAUSES  DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.			(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). <span style="font-size: 1.5em;">Chronic alcoholism</span>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.5em;">6 mo.</span>		
19A. DATE OF OPERATION <span style="font-size: 1.2em;">7/31/71</span>			19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">Colon</span>		
20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">No</span>			20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>			21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)		
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>			21F. HOW DID INJURY OCCUR?		
22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1/22</span> 19 <span style="font-size: 1.2em;">72</span> to <span style="font-size: 1.2em;">1/24</span> 19 <span style="font-size: 1.2em;">72</span> and that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">1/22</span> 19 <span style="font-size: 1.2em;">72</span> and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
23A. SIGNATURE <span style="font-size: 1.5em;">[Signature]</span>			23B. DATE SIGNED <span style="font-size: 1.5em;">1/25/72</span>		
23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">Dr. George Vash</span>			23D. ADDRESS <span style="font-size: 1.2em;">206 S. Gilmore Street</span>		
24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">Burial</span>			24B. DATE <span style="font-size: 1.2em;">1-29-72</span>		
24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Dulaney Valley Memorial Gardens</span>			24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Timonium, Md.</span>		
25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 26 1972</span>			25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">Robert E. Taylor, M.D.</span>		
25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">H. W. Jenkins &amp; Sons Co.</span>			25D. ADDRESS <span style="font-size: 1.2em;">4905 York Road Balto., Md. 21212</span>		



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00867		72 00867	
CERTIFICATE OF DEATH				BIRTH NO.		REG. NO.	
1. NAME OF DECEASED (Type or Print)		2. DATE AND HOUR OF DEATH		3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD		4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)	
Adeline E. Goren		Jan. 24/72 2 <sup>30</sup> A. M.		Sinai Hospital		Mayland 2717	
5. SEX Female		6. RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 78	
9. AGE (In years last birthday)		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
78		Housewife		New York		USA.	
13. FATHER'S NAME David Ehrlich				14. MOTHER'S MAIDEN NAME Sophie			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
NO				MRS. FRANCES LERNER, 8012 WOODGATE CT., APT. B			
18. CAUSE OF DEATH 410.0 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Myocardial infarct sudden		(B) DUE TO, OR AS A CONSEQUENCE OF: Hypertensive cardio-vascular disease at least 4 years		(C) DUE TO, OR AS A CONSEQUENCE OF:	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (APPROX.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from 5-2 1972 to 1-24 1972, that (I) (we) last saw the deceased alive on Jan. 3 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Reuben Hoffman, M.D.				23B. DATE SIGNED 1-24-72		23C. PHYSICIAN'S NAME (Type) REUBEN HOFFMAN, M.D.	
23D. ADDRESS P.O. Box 36 2nd St., Baltimore, Md. 21211							
24A. BURIAL CREMATION, REMOVAL (Specify)		24B. DATE		24C. NAME OF CEMETERY or CREMATORY		24D. LOCATION (City, town, or county) (State)	
Burial		Jan 24/72		Hebrew Friendship		Baltimore, Maryland	
25A. DATE REC'D BY HEALTH DEPT.		25B. NAME OF REGISTRAR		25C. FUNERAL DIRECTOR		25D. ADDRESS	
JAN 26 1972		Reuben Hoffman, M.D.		Solomon Stans - 6010 Reisterstown			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>G-356</b></span> <span><b>00868</b></span> </div>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		<b>REG. NO. 72 00868</b>	
<b>BIRTH NO.</b> 1. NAME OF DECEASED (Type or Print) <b>REBECCA GITOMER</b>		2. DATE AND HOUR OF DEATH <b>JANUARY 22, 1972 11:10 A.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CONCORD HOUSE, APT. 719 2500 W. BELVEDERE AVENUE</b>		4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>2717</b> C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2500 W. BELVEDERE AVENUE, APT. 719</b>			
5. SEX <b>FEMALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-10-1890</b>	9. AGE (In years last birthday) <b>81</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>AT HOME</b>		11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>	
13. FATHER'S NAME <b>UNKNOWN</b>		14. MOTHER'S MAIDEN NAME <b>HANNAH ?</b>			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <b>MR. JACOB GITOMER, 4014 BROOKHILL RD. #21215</b>	
18. <b>412.11</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>C.V.A.</b> (B) <b>HASHED</b> DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b> <b>10 years</b>	
II					
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>3/5</b> 19 <b>46</b> to <b>1/22</b> 19 <b>72</b> , that (I) (we) lost saw the deceased alive on <b>1/22</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Israhel Zinberg MD</b>				23B. DATE SIGNED <b>1/22/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>ISRAEL ZINBERG</b>		23D. ADDRESS <b>4000 W. NORTHERN PKWY.</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-24-72</b>		24C. NAME OF CEMETERY OR CREMATORY <b>HAR ZION TIFERETH ISRAEL</b>	
24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>			
25B. NAME OF REGISTRAR <b>Israhel Zinberg MD</b>		25C. FUNERAL DIRECTOR ADDRESS <b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>			

100000

100000

100000

100000

100000

100000

100000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <span style="float: right;">72 00869</span>	
<b>BIRTH NO.</b> <div style="font-size: 2em; font-weight: bold;">C-540</div> <div style="font-size: 1.5em; font-weight: bold;">72 00869</div>		CERTIFICATE OF DEATH			
<b>1. NAME OF DECEASED</b> <small>(Type or Print)</small> <div style="font-size: 1.2em;">GISA CHMIEL</div>			<b>2. DATE AND HOUR OF DEATH</b> <div style="font-size: 1.2em;">1/23/72 3:30 A.M.</div>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <div style="font-size: 1.1em;">FULL NAME OF HOSPITAL OR INSTITUTION <span style="margin-left: 20px;">(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</span></div> <div style="font-size: 1.2em;">SINAI HOSPITAL OF BALTIMORE INC.</div>			<b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission) <div style="font-size: 1.1em;">A. STATE <span style="margin-left: 20px;">B. COUNTY</span></div> <div style="font-size: 1.2em;">MARYLAND 2720</div> <div style="font-size: 1.1em;">C. CITY OR TOWN <span style="margin-left: 20px;">D. INSIDE CITY LIMITS?</span></div> <div style="font-size: 1.2em;">BALTIMORE YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></div> <div style="font-size: 1.1em;">E. STREET AND NUMBER</div> <div style="font-size: 1.2em;">7022 SURREY DRIVE</div>		
<b>5. SEX</b> <div style="font-size: 1.2em;">FEMALE</div>	<b>6. RACE</b> <div style="font-size: 1.2em;">WHITE</div>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <div style="font-size: 1.2em;">XXXXXXXXXX</div>		<b>9. AGE</b> (In years last birthday) <span style="margin-left: 20px;">10. Under 1 Yr. Months Days</span> <div style="font-size: 1.2em;">76 76</div>
<b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <div style="font-size: 1.2em;">HOUSEWIFE</div>		<b>10B. KIND OF BUSINESS OR INDUSTRY</b> <div style="font-size: 1.2em;">AT HOME</div>		<b>11. BIRTHPLACE</b> (State or foreign country) <div style="font-size: 1.2em;">POLAND</div>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <div style="font-size: 1.2em;">USA</div>		<b>13. FATHER'S NAME</b> <div style="font-size: 1.2em;">JOSEPH KERSHNOVITZ</div>			
<b>14. MOTHER'S MAIDEN NAME</b> <div style="font-size: 1.2em;">UNKNOWN</div>		<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <div style="font-size: 1.2em;">NO</div>			
<b>16. SOCIAL SECURITY NO.</b> <div style="font-size: 1.2em;">NO</div>		<b>17. INFORMANT</b> <span style="margin-left: 20px;">ADDRESS</span> <div style="font-size: 1.2em;">DR. MAX FRANK, RT. 2, BOX 246, BAY HEAD ROAD ANNAPOLIS, MD. 21401</div>			
CAUSE OF DEATH					
<div style="font-size: 1.2em;">18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</div> <div style="font-size: 1.1em;">(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</div> <div style="font-size: 1.2em;">ANTECEDENT CAUSES</div> <div style="font-size: 1.1em;">DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</div> <div style="font-size: 1.2em;">II</div> <div style="font-size: 1.1em;">OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</div>					
<div style="font-size: 1.2em;">19A. DATE OF OPERATION</div>		<div style="font-size: 1.2em;">19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</div>		<div style="font-size: 1.2em;">20A. AUTOPSY? (Yes or No)</div> <div style="font-size: 1.2em;">NO</div>	
<div style="font-size: 1.2em;">20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</div>		<div style="font-size: 1.2em;">21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</div> <div style="font-size: 1.1em;">(notify medical examiner)</div>			
<div style="font-size: 1.2em;">21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</div>		<div style="font-size: 1.2em;">21C. WHERE DID INJURY OCCUR?</div> <div style="font-size: 1.1em;">(If in Baltimore City, give exact location)</div>			
<div style="font-size: 1.2em;">21D. TIME OF INJURY (APPROX.)</div>		<div style="font-size: 1.2em;">21E. INJURY OCCURRED</div> <div style="font-size: 1.1em;">While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></div>		<div style="font-size: 1.2em;">21F. HOW DID INJURY OCCUR?</div>	
<div style="font-size: 1.2em;">22. I certify that (I) (this hospital) attended the deceased from <span style="margin-left: 20px;">1/21</span> 19 <span style="margin-left: 20px;">72</span> to <span style="margin-left: 20px;">1/23</span> 19 <span style="margin-left: 20px;">72</span></div> <div style="font-size: 1.2em;">that (I) (we) lost saw the deceased alive on <span style="margin-left: 20px;">1/23</span> 19 <span style="margin-left: 20px;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</div>					
<div style="font-size: 1.2em;">23A. SIGNATURE</div> <div style="font-size: 1.2em;">Max C Frank MD</div>				<div style="font-size: 1.2em;">23B. DATE SIGNED</div> <div style="font-size: 1.2em;">1/23/72</div>	
<div style="font-size: 1.2em;">23C. PHYSICIAN'S NAME (Type)</div> <div style="font-size: 1.2em;">MAX C FRANK MD</div>				<div style="font-size: 1.2em;">23D. ADDRESS</div> <div style="font-size: 1.2em;">425 S. Ritchie Hwy - Ocean Park 21061</div>	
<div style="font-size: 1.2em;">24A. BURIAL CREMATION, REMOVAL (Specify)</div> <div style="font-size: 1.2em;">BURIAL</div>		<div style="font-size: 1.2em;">24B. DATE</div> <div style="font-size: 1.2em;">1-24-72</div>		<div style="font-size: 1.2em;">24C. NAME of CEMETERY or CREMATORY</div> <div style="font-size: 1.2em;">ANSHE EMUNAH</div>	
<div style="font-size: 1.2em;">24D. LOCATION</div> <div style="font-size: 1.2em;">BALTIMORE, MARYLAND</div>		<div style="font-size: 1.2em;">25A. DATE REC'D BY HEALTH DEPT.</div> <div style="font-size: 1.2em;">JAN 26 1972</div>			
<div style="font-size: 1.2em;">25B. NAME OF REGISTRAR</div> <div style="font-size: 1.2em;">SOL LEVINSON &amp; BROS.</div>		<div style="font-size: 1.2em;">25C. FUNERAL DIRECTOR</div> <div style="font-size: 1.2em;">ADDRESS</div> <div style="font-size: 1.2em;">6010 REISTERSTOWN ROAD</div>			

RECEIVED

RECEIVED

RECEIVED

RECEIVED

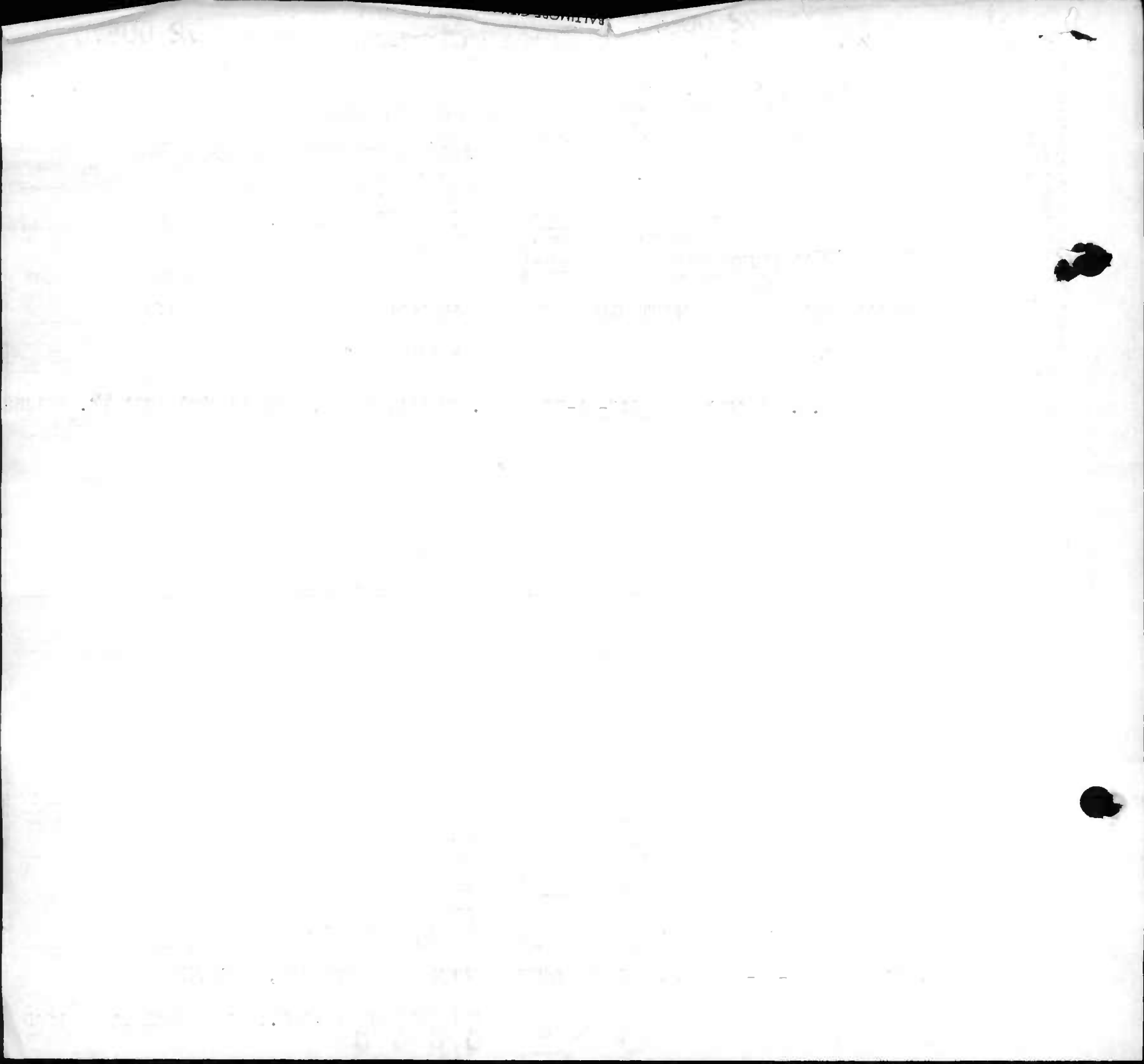
X



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

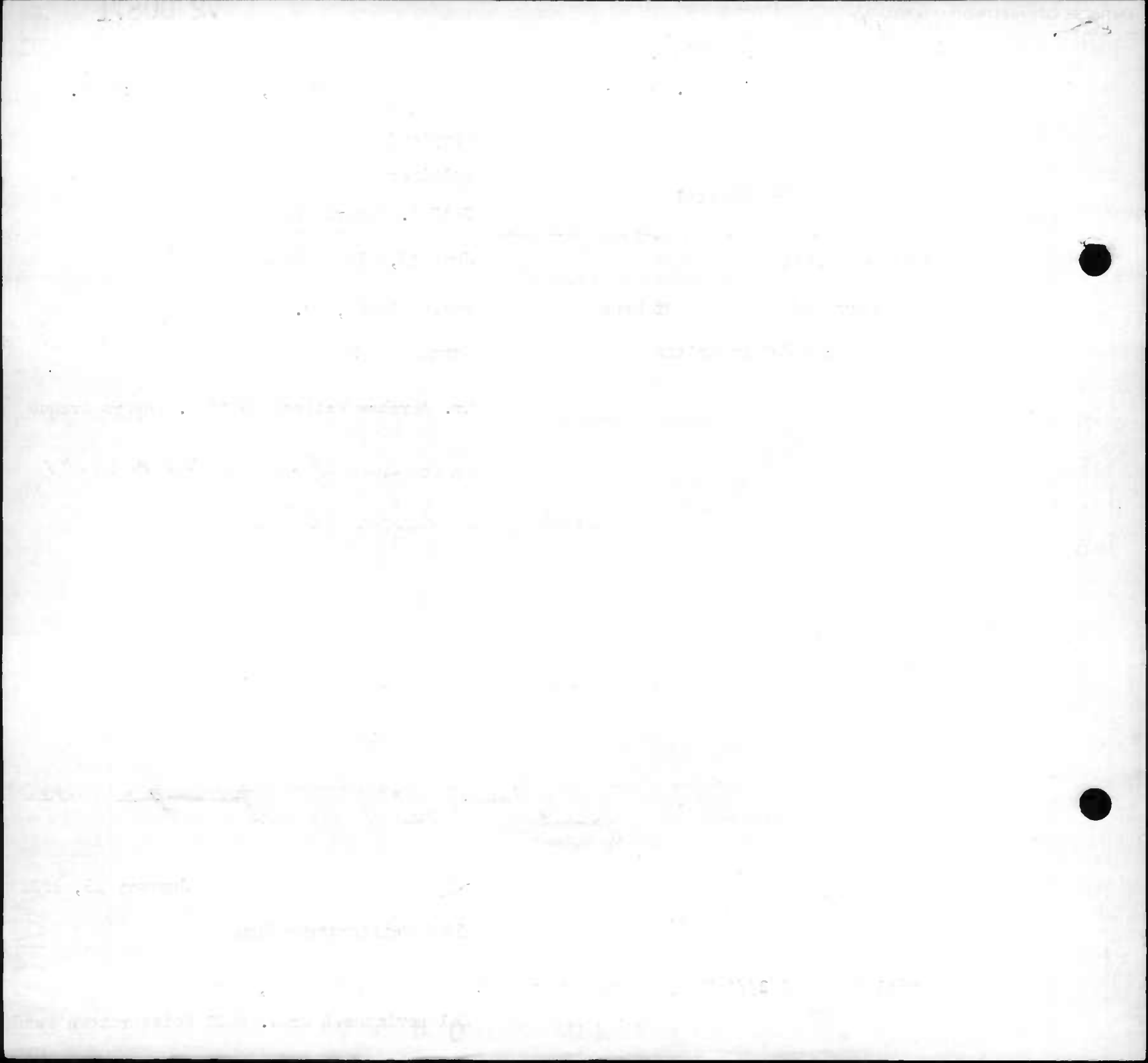
Baltimore City Health Department				REG. NO. <u>72 00870</u>
<b>BIRTH NO.</b> <b>1. NAME OF DECEASED</b> (Type or Print) <u>Sachs, Harry J. SACHS</u>		<b>2. DATE AND HOUR OF DEATH</b> <u>1/22/72</u> <u>3:00A.M.</u>		
<b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b>  <b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (If not in hospital or institution, give street address or location) <u>Mercy Hospital Inc.</u>		<b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission) A. STATE <u>Md.</u> B. COUNTY <u>2653</u> <b>C. CITY OR TOWN</b> <u>Baltimore</u> <b>D. INSIDE CITY LIMITS?</b> YES <input type="checkbox"/> NO <input type="checkbox"/> <b>E. STREET AND NUMBER</b> <u>3003 Sinclair La.</u>		
<b>5. SEX</b> <u>Male</u>	<b>6. RACE</b> <u>WHITE</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>11/16/05</u> <b>9. AGE (in years last birthday)</b> <u>66</u> <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>DOOR KX HOST</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>NEW YORK</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>LOUIS SACHS</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>SARAH ?</u>		
<b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>W.W. II ARMY</u>		<b>16. SOCIAL SECURITY NO.</b> <u>217-01-7343</u> <b>17. INFORMANT</b> <u>MR. CARROLL SACHS, 4235 MILFORD MILL RD. #21208</u> <b>ADDRESS</b>		
<b>18. CAUSE OF DEATH</b> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <u>410.91</u> <b>ANTECEDENT CAUSES</b> DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. (A) IMMEDIATE CAUSE <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF: (B) <u>PULMONARY EMBOLUS</u> DUE TO, OR AS A CONSEQUENCE OF: (C) <u>ANT. MYOCARDIAL INFARCTION</u> <b>II</b> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b> <u>ASCVD</u> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>				
<b>19A. DATE OF OPERATION</b> <u>0</u>		<b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b> <b>20A. AUTOPSY?</b> (Yes or No) <u>NO</u> <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>		
<b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>		<b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.) <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)		
<b>21D. TIME OF INJURY (APPROX.)</b> (Month) (Day) (Year) (Hour)		<b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		
<b>21F. HOW DID INJURY OCCUR?</b>		<b>22. I certify that (I) (this hospital) attended the deceased from</b> <u>1/17</u> <b>19</b> <u>72</u> <b>to</b> <u>1/22</u> <b>19</b> <u>72</u> <b>that (I) (we) lost saw the deceased alive on</b> <u>1/22</u> <b>19</b> <u>72</u> <b>and that in (my) (our) opinion death occurred on the date</b> <u>1/22</u> <b>19</b> <u>72</u> <b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b>		
<b>23A. SIGNATURE</b> <u>M. V. Edelstein</u>		<b>23B. DATE SIGNED</b> <u>1-22-72</u>		
<b>23C. PHYSICIAN'S NAME (Type)</b> <u>M. V. EDELSTEIN</u>		<b>23D. ADDRESS</b> <u>Mercy Hospital</u>		
<b>24A. BURIAL CREMATION, REMOVAL (Specify)</b> <u>BURIAL</u>		<b>24B. DATE</b> <u>1-24-72</u>		
<b>24C. NAME OF CEMETERY OR CREMATORY</b> <u>BETH JACOB ANSHE VESHEAR</u>		<b>24D. LOCATION</b> (City, town, or county) (State) <u>ROSEDALE, MARYLAND</u>		
<b>25A. DATE REC'D BY HEALTH DEPT.</b> <u>JAN 26 1972</u>		<b>25B. NAME OF REGISTRAR</b> <u>SOL LEVINSON &amp; BROS.</u>		
<b>25C. FUNERAL DIRECTOR</b> <u>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</u>		<b>ADDRESS</b>		



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

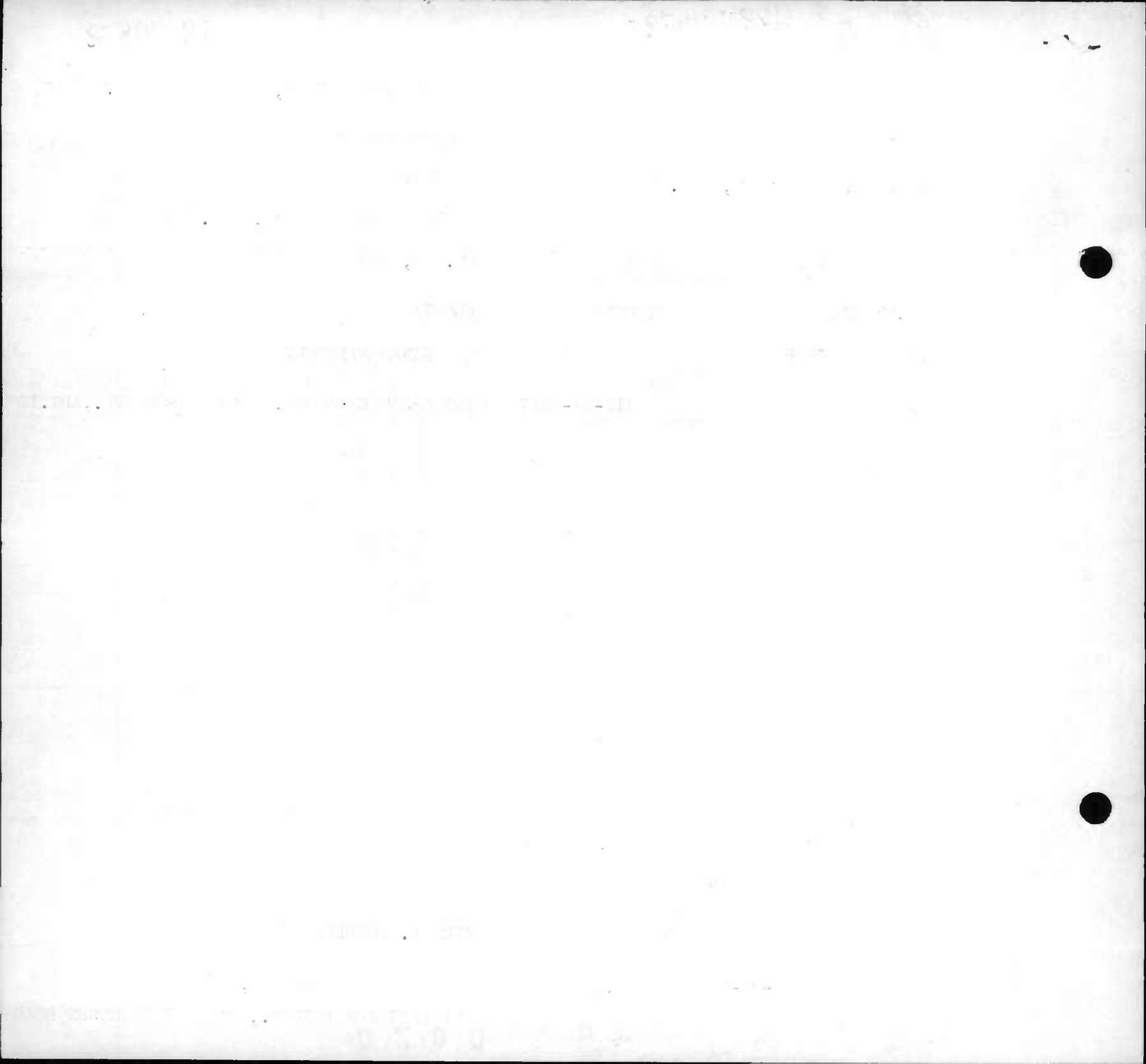
BALTIMORE CITY HEALTH DEPARTMENT				72 00871		REG. NO.	
BIRTH NO. 10-420				72 00871			
1. NAME OF DECEASED (Type or Print) SYLVIA K. WALLACH				2. DATE AND HOUR OF DEATH January 22, 1972 2:15 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 42 Sinai Hospital				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE Maryland C. CITY OR TOWN Baltimore E. STREET AND NUMBER 3817 W. Rogers Avenue			
5. SEX Female		6. RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH June 13, 1913	
9. AGE (In years last birthday) 58		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		11. BIRTHPLACE (State or foreign country) Philadelphia, Pa.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Late Julius Kaizen				14. MOTHER'S MAIDEN NAME Sarah ?			
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Mr. Abraham Wallach 3817 W. Rogers Avenue	
18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.) 136.01 CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Carcinoma of gall bladder (B) DUE TO, OR AS A CONSEQUENCE OF: with metastatic liver (C) _____ ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). 19A. DATE OF OPERATION Jan 1971				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma of gall bladder			
20A. AUTOPSY? (Yes or No) No				20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)			
21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)				21D. TIME OF INJURY (Month) (Day) (Year) (Hour)			
21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (this hospital) attended the deceased from Jan 21, 1972 to Jan 22, 1972, that (I) (we) last saw the deceased alive on Jan 22, 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
23A. SIGNATURE Milton E. Lowman				23B. DATE SIGNED January 23, 1972			
23C. PHYSICIAN'S NAME (Type) Milton Lowman				23D. ADDRESS 1401 Reisterstown Road			
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1/24/1972			
24C. NAME OF CEMETERY or CREMATORY Hebrew Friendship				24D. LOCATION (City, town, or county) (State) Baltimore, Maryland			
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1972				25B. NAME OF REGISTRAR Sol Levinson & Bros.			
25C. FUNERAL DIRECTOR ADDRESS				25D. ADDRESS 6010 Reisterstown Road			



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>K-561</b>				BALTIMORE CITY HEALTH DEPARTMENT				REG. NO. <b>72 00872</b>			
1. NAME OF DECEASED (Type or Print)				2. DATE AND HOUR OF DEATH							
<b>CELIA KAMAROFF</b>				<b>JANUARY 20, 1972</b>				<b>4<sup>25</sup> P. M.</b>			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)							
FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)				A. STATE				B. COUNTY			
<b>2713 HANSON AVENUE, APT. 1 B</b>				<b>MARYLAND</b>				<b>2740</b>			
				C. CITY OR TOWN				D. INSIDE CITY LIMITS?			
				<b>BALTIMORE</b>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
				E. STREET AND NUMBER							
				<b>2713 HANSON AVENUE, APT. 1 B</b>							
5. SEX		6. RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		If Under 1 Yr. Months: Days: Hours: Min.	
<b>FEMALE</b>		<b>WHITE</b>		<b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		<b>OCT. 25, 1889</b>		<b>82</b>			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10B. KIND OF BUSINESS OR INDUSTRY				11. BIRTHPLACE (State or foreign country)			
<b>HOUSEWIFE</b>				<b>AT HOME</b>				<b>RUSSIA</b>			
12. CITIZEN OF WHAT COUNTRY?				<b>USA</b>							
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME							
<b>JOEL KAMAROFF</b>				<b>SARAH SILANSKY</b>							
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS			
<b>NO</b>				<b>215-54-3557</b>				<b>MISS SARAH KAMAROFF, 2713 HANSON AVE., APT. 1B</b>			
18. <b>4-12-21</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)				CAUSE OF DEATH <b>Hypertensive Arteriosclerosis, C.V.D.</b> (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:  (B) DUE TO, OR AS A CONSEQUENCE OF:  (C) DUE TO, OR AS A CONSEQUENCE OF:				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b>			
ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.											
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).											
19A. DATE OF OPERATION				19B. CONDITION FOR WHICH OPERATION WAS PERFORMED				20A. AUTOPSY? (Yes or No)			
								20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)				21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)				21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)				21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>				21F. HOW DID INJURY OCCUR?			
22. I certify that (I) (the hospital) attended the deceased from <b>1958</b> to <b>Jan 20</b> 1972, that (I) (we) lost saw the deceased alive on <b>Jan 8</b> 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.											
23A. SIGNATURE <b>Lester A. Wall</b>				23B. DATE SIGNED <b>1/21/72</b>							
23C. PHYSICIAN'S NAME (Type)				23D. ADDRESS							
<b>LESTER WALL</b>				<b>4300 N. CHARLES STREET</b>							
24A. BURIAL CREMATION, REMOVAL (Specify)				24B. DATE				24C. NAME OF CEMETERY or CREMATORY			
<b>BURIAL</b>				<b>1-23-72</b>				<b>BETH TFILOH</b>			
25A. DATE REC'D BY HEALTH DEPT.				25B. NAME OF REGISTRAR				25C. FUNERAL DIRECTOR ADDRESS			
<b>JAN 26 1972</b>				<b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>							



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <b>H-620</b>		BALTIMORE CITY HEALTH DEPARTMENT	
72 00873		CERTIFICATE OF DEATH	
1. NAME OF DECEASED (Type or Print) <b>Samuel Hirsh</b>		2. DATE AND HOUR OF DEATH <b>1-21-72 at 1 7 25 P. M.</b>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>Lutheran Hospital 730 Ashburton St # 16</b>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <b>MD</b> B. COUNTY <b>BALTO</b> C. CITY OR TOWN <b>Balto.</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <b>2023 BEACHWOOD AVENUE #21207</b>	
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 25, 1889</b>
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>TAILOR</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>SHOP</b>	9. AGE (In years last birthday) <b>82</b>
11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>HIRSH</b>		14. MOTHER'S MAIDEN NAME	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>214-03-3296</b>	
17. INFORMANT <b>MRS. BESSIE HIRSH, 2023 BEACHWOOD AVE. #21207</b>		ADDRESS	
18. CAUSE OF DEATH DISEASE OR CONDITION DIRECTLY LEADING TO DEATH <b>Possible myocardial infarction with</b> (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. <b>Cardiac Arrhythmia</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).			
19A. DATE OF OPERATION	19B. CONDITION FOR WHICH OPERATION WAS PERFORMED	20A. AUTOPSY? (Yes or No) <b>No</b>	20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)	21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)	21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>1/12</b> 19 <b>72</b> to <b>1/21</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/21</b> 19 <b>72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.			
23A. SIGNATURE <b>Arjana Doshi</b>		23B. DATE SIGNED <b>1/21/72</b>	
23C. PHYSICIAN'S NAME (Type) <b>ARJANA DOSHI</b>		23D. ADDRESS <b>LUTHERAN HOSPITAL</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>	24B. DATE <b>1-23-72</b>	24C. NAME OF CEMETERY or CREMATORY <b>SHOMRE HADATH</b>	24D. LOCATION (City, town, or county) (State) <b>ROSEDALE, MARYLAND</b>
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>	25B. NAME OF REGISTRAR <b>John E. Fisher M.D.</b>	25C. FUNERAL DIRECTOR <b>SOI LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>	

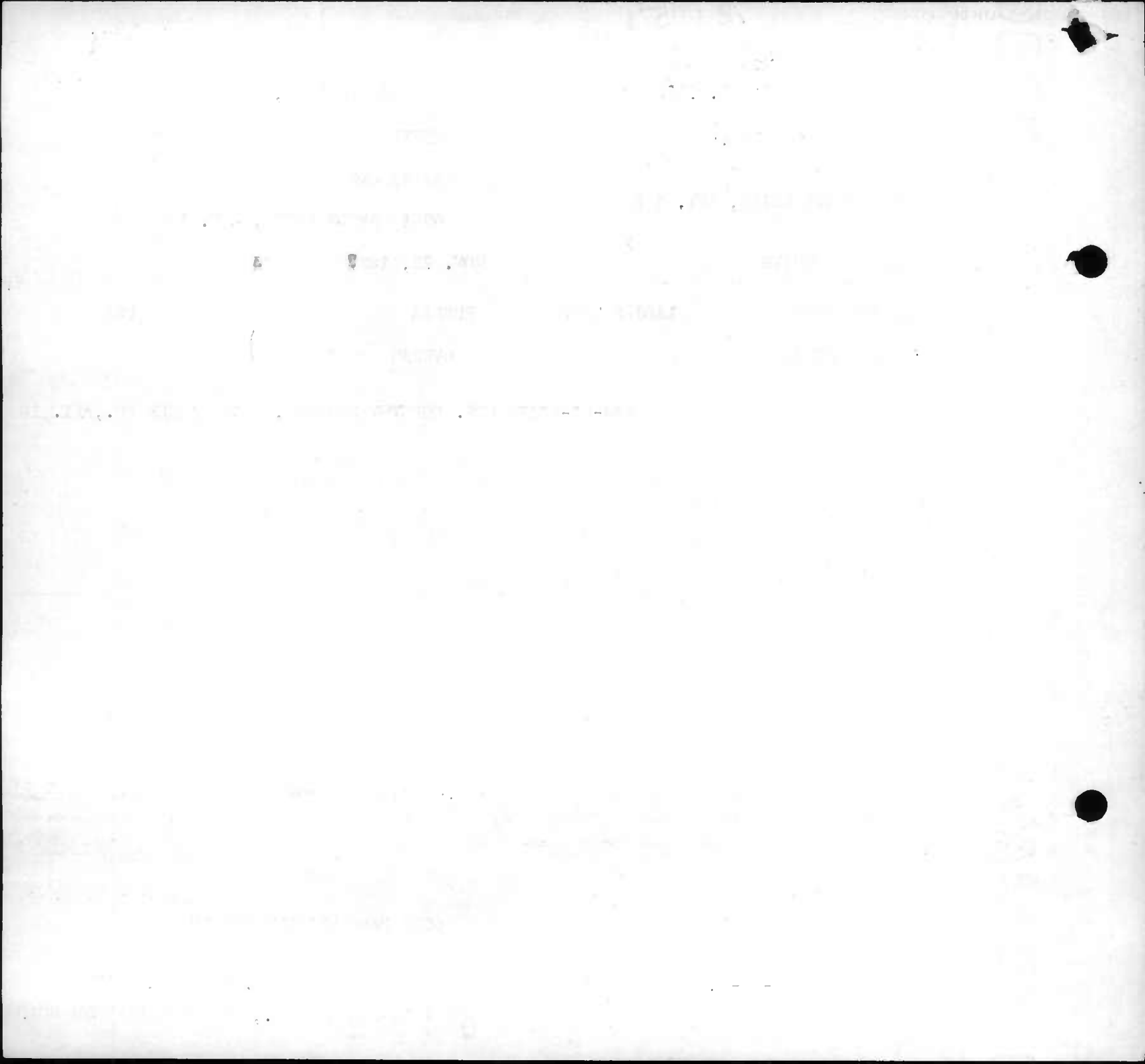
1/11 1911  
1911



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BIRTH NO. <span style="float: right;">72 00874</span>		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. <span style="float: right;">72 00874</span>	
1. NAME OF DECEASED (Type or Print) <b>JULIUS M. SUSSMAN</b>			2. DATE AND HOUR OF DEATH <b>JANUARY 20, 1972 5:30 P.M.</b>		
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD			4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission) A. STATE <b>MARYLAND</b> B. COUNTY <b>BALT.</b>		
FULL NAME OF HOSPITAL OR INSTITUTION <b>00</b> 6968 MARSUE DRIVE, APT. 1 B			C. CITY OR TOWN <b>BALTIMORE</b>		D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>
			E. STREET AND NUMBER <b>6968 MARSUE DRIVE, APT. 1 B</b>		
5. SEX <b>MALE</b>	6. RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOV. 25, 1897</b>	9. AGE (In years lost birthday) <b>74</b>	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>MANUFACTURER</b>		10B. KIND OF BUSINESS OR INDUSTRY <b>LADIES HATS</b>	11. BIRTHPLACE (State or foreign country) <b>RUSSIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>ISAAC SUSSMAN</b>			14. MOTHER'S MAIDEN NAME <b>DVERAH ?</b>		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>084-01-8317A</b>	17. INFORMANT <b>MRS. DOROTHY SUSSMAN, 6968 MARSUE DR., APT. 1B</b>		
18. <b>4-10-9 I</b> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) <b>ACUTE Coronary Occlusion immediate</b> ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost. <b>Coronary arteriosclerosis 5 years</b>			CAUSE OF DEATH (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: (B) DUE TO, OR AS A CONSEQUENCE OF: (C) _____		
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION <b>0</b>		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <b>Nov 10 1956</b> to <b>Jan 20 1972</b> , that (I) (we) last saw the deceased alive on <b>Nov 9 1971</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.					
23A. SIGNATURE <b>Irvin Sauber</b>				23B. DATE SIGNED <b>Jan 21, 72</b>	
23C. PHYSICIAN'S NAME (Type) <b>IRVIN SAUBER</b>				23D. ADDRESS <b>6905 PARK HEIGHTS AVENUE</b>	
24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>		24B. DATE <b>1-23-72</b>		24C. NAME OF CEMETERY or CREMATORY <b>BETH TFILOH</b>	
24D. LOCATION <b>BALTIMORE, MARYLAND</b>		25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>			
25B. NAME OF REGISTRAR <b>SOL LEVINSON</b>		25C. FUNERAL DIRECTOR ADDRESS <b>&amp; BROS., 6010 REISTERSTOWN ROAD</b>			



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT				72 00875 CERTIFICATE OF DEATH		REG. NO. 72 00875	
BIRTH NO. 7-655				1. NAME OF DECEASED (Type or Print) FREIMAN, HERBERT. G.		2. DATE AND HOUR OF DEATH 1/20/72 10.30 P.M.	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>CERTIFICATE AMENDED</b> SINAI HOSPITAL OF BALTIMORE 3-16-72				4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE MARYLAND. B. COUNTY 2730		C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
5. SEX MALE 6. RACE WHITE 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH 2/29/16 9. AGE (In years last birthday) 55		10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) C.P.A.				10B. KIND OF BUSINESS OR INDUSTRY ACCOUNTING		11. BIRTHPLACE (State or foreign country) BALTIMORE, MARYLAND	
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME JOSEPH FREIMAN			
14. MOTHER'S MAIDEN NAME UNKNOWN Reba Gordon				15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO. 215-01-2543				17. INFORMANT ADDRESS MRS. SYLVIA FREIMAN, 2826 DAMASCUS CT., APT. F			
18. CAUSE OF DEATH I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF: (B) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO, OR AS A CONSEQUENCE OF: (C) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 DAYS	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).							
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No) NO		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (A) (this hospital) attended the deceased from 1/5/1972 to 1/20/1972 that (B) (we) lost saw the deceased alive on 1/20 1972 and that (C) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (D) (We) (did) (did not) view the body after death.							
23A. SIGNATURE Andreas A. Petsas M.D.				23B. DATE SIGNED 1/20/72		23C. PHYSICIAN'S NAME (Type) ANDREAS A. PETSAS	
23D. ADDRESS SINAI HOSPITAL OF BALTIMORE				24A. BURIAL CREMATION, REMOVAL (Specify) BURIAL			
24B. DATE 1-23-72		24C. NAME OF CEMETERY OR CREMATORY BETH EL MEMORIAL PARK		24D. LOCATION (City, town, or county) (State) RANDALLSTOWN, MARYLAND			
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1972				25B. NAME OF REGISTRAR J. J. 972000		25C. FUNERAL DIRECTOR ADDRESS SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD	

3-16-1972,- Mother's full maiden name added - Rita Gordon - Correction made from  
Birth Certificate of Herbert Freiman-Date of birth Feb. 29, 1916 - B-24456  
Affidavit signed by Wife, Sylvia E. Freiman. HRS

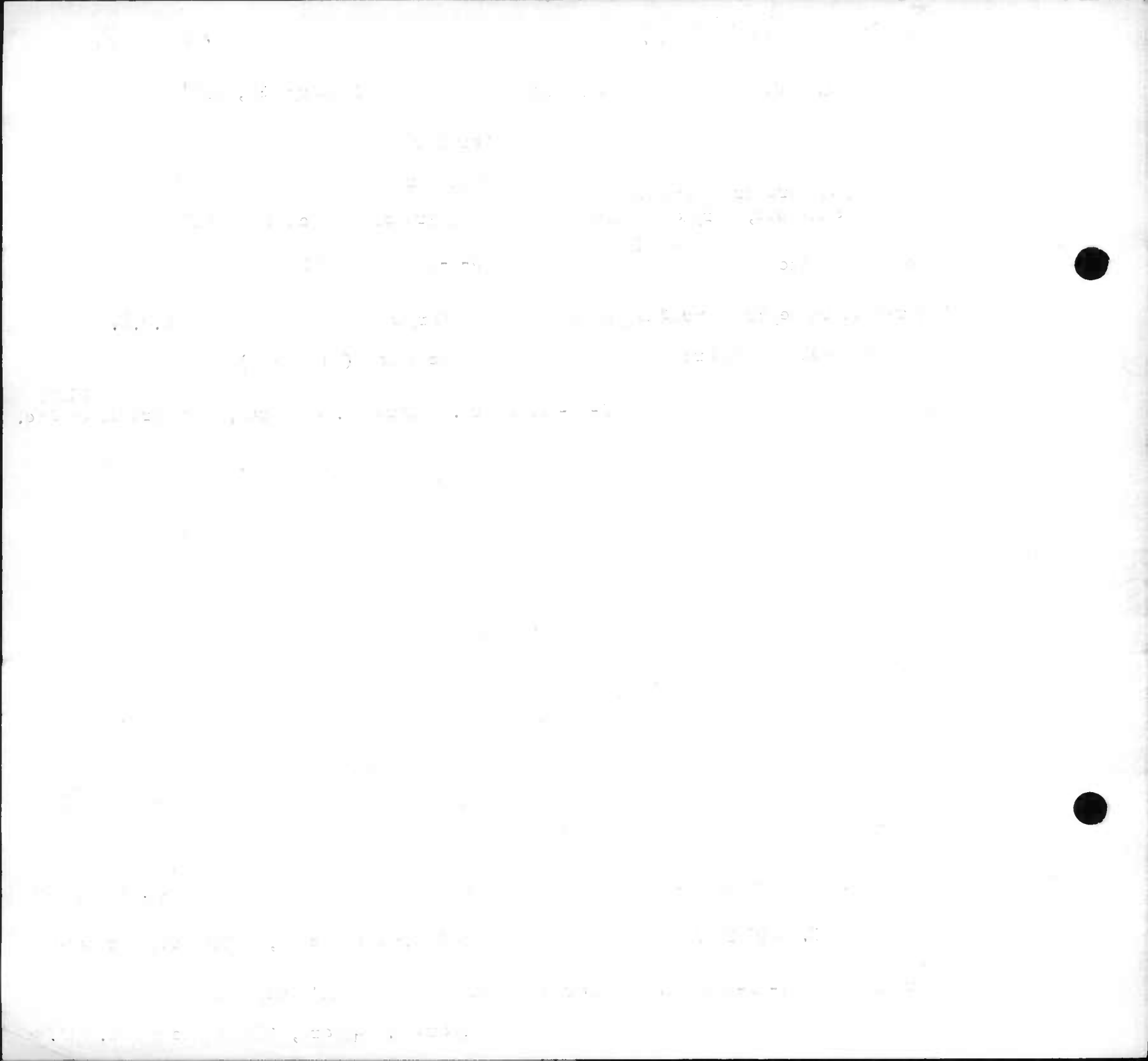
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

K-400		72 00876		BALTIMORE CITY HEALTH DEPARTMENT		REG. NO. 72 00876	
BIRTH NO.				1			
1. NAME OF DECEASED (Type or Print) KELLY, William I.				2. DATE AND HOUR OF DEATH 1-21-72 12 P. M.			
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD				4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) A. STATE md. B. COUNTY 1608			
FULL NAME OF HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL OF MARYLAND				C. CITY OR TOWN Baltimore		D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)				E. STREET AND NUMBER 828 Wildwood Pkwy - 21229			
5. SEX M	6. RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5-21-90	9. AGE (In years last birthday) 81	If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.		
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist			10B. KIND OF BUSINESS OR INDUSTRY Md. Glass Co.		11. BIRTHPLACE (State or foreign country) Maryland		
13. FATHER'S NAME William Kelly			14. MOTHER'S MAIDEN NAME Annie Creamer		12. CITIZEN OF WHAT COUNTRY? U.S.A.		
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) No			16. SOCIAL SECURITY NO. 212-10-6118		17. INFORMANT Mrs. Evelyn G. Richards, 828 Wildwood Parkway		
18. CAUSE OF DEATH 430.4 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.				(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: SUBARACHNOID HEMORRAGE (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)		20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)			
21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I certify that (1) (this hospital) attended the deceased from 1-21-1972 to 1-21-1972 that (1) (we) last saw the deceased alive on 1-21-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.							
23A. SIGNATURE J. H. 2 J. H. 2				23B. DATE SIGNED 1-21-72		23C. PHYSICIAN'S NAME (Type) ARAZ ARAIN M.D.	
24A. BURIAL CREMATION, REMOVAL (Specify) Burial				24B. DATE 1-25-1972		24C. NAME OF CEMETERY or CREMATORY Loudon Park Cemetery	
25A. DATE REC'D BY HEALTH DEPT. JAN 26 1972				25B. NAME OF REGISTRAR Howard H. Hubbard		25C. FUNERAL DIRECTOR ADDRESS 4107 Wilkens Ave, 21229	



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<p><b>S-632</b>      <b>72 00877</b>      <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p> <p style="text-align: right;">REG. NO. <b>72 00877</b></p>			
<p>BIRTH NO. <b>1</b></p> <p>1. NAME OF DECEASED (Type or Print) <b>SAMUEL SCHWARTZ</b></p>		<p>2. DATE AND HOUR OF DEATH <b>January 22, 1972</b></p>	
<p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>3001 Frederick Avenue Baltimore, Maryland 21223</b></p>		<p>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission) A. STATE <b>Maryland</b>      B. COUNTY <b>2006</b></p> <p>C. CITY OR TOWN <b>Baltimore</b>      D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>E. STREET AND NUMBER <b>3001 Frederick Avenue 21223</b></p>	
<p>5. SEX <b>Male</b></p>	<p>6. RACE <b>White</b></p>	<p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>	<p>8. DATE OF BIRTH <b>5-6-1898</b></p>
<p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Storekeeper</b></p>		<p>10B. KIND OF BUSINESS OR INDUSTRY <b>Self Employed</b></p>	<p>9. AGE (In years last birthday) <b>73</b></p>
<p>11. BIRTHPLACE (State or foreign country) <b>Maryland</b></p>		<p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>	
<p>13. FATHER'S NAME <b>Michael Schwartz</b></p>		<p>14. MOTHER'S MAIDEN NAME <b>Rebecca (Unknown)</b></p>	
<p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b></p>		<p>16. SOCIAL SECURITY NO. <b>215-03-4558A</b></p>	<p>17. INFORMANT ADDRESS <b>21223</b> <b>Mrs. Mildred V. Schwartz, 3001 Frederick Ave.</b></p>
<p>18. CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <b>Carcinoma Lung</b> <b>Carcinoma Colon</b></p> <p>(B) DUE TO, OR AS A CONSEQUENCE OF: <b>Arteriosclerosis</b></p> <p>(C) _____</p>			
<p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>?</b></p>			
<p>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). <b>Arteriosclerosis</b></p>			
<p>19A. DATE OF OPERATION <b>20 Nov 1971</b></p>		<p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Cad Lung - Bronchoscopy</b></p>	
<p>20A. AUTOPSY? (Yes or No) <b>NO</b></p>		<p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? _____</p>	
<p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>		<p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) _____</p>	
<p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) _____</p>		<p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) _____</p>	
<p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/></p>		<p>21F. HOW DID INJURY OCCUR? _____</p>	
<p>22. I certify that (I) (this hospital) attended the deceased from <b>1971</b> to <b>Jan 22</b> 19<b>72</b> that (I) <del>(we)</del> last saw the deceased alive on <b>Dec 8</b> 19<b>71</b> and that (in my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above. (I) <del>(We)</del> (did) (did not) view the body after death.</p>			
<p>23A. SIGNATURE <b>I. Earl Pass</b></p>		<p>23B. DATE SIGNED <b>1/24/72</b></p>	
<p>23C. PHYSICIAN'S NAME (Type) <b>I. Earl Pass</b></p>		<p>23D. ADDRESS <b>4001 Wilkens Avenue, Baltimore, Maryland</b></p>	
<p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>		<p>24B. DATE <b>1-25-1972</b></p>	
<p>24C. NAME of CEMETERY or CREMATORY <b>Loudon Park Cemetery</b></p>		<p>24D. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b></p>	
<p>25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b></p>		<p>25B. NAME OF REGISTRAR <b>Robert E. Galt</b></p>	
<p>25C. FUNERAL DIRECTOR <b>Howard H. Hubbard</b></p>		<p>ADDRESS <b>4107 Wilkens Ave., 21229</b></p>	





# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

<div style="display: flex; justify-content: space-between;"> <span><b>S-351</b></span> <span><b>72 00878</b></span> </div>		<b>BALTIMORE CITY HEALTH DEPARTMENT</b> <b>CERTIFICATE OF DEATH</b>		REG. NO. <b>72 00878</b>	
BIRTH NO. <span style="float: right;"><b>1</b></span>		1. NAME OF DECEASED (Type or Print) <i>William M. Stumpf</i>		2. DATE AND HOUR OF DEATH <i>1/21/72</i>	
3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  FULL NAME OF HOSPITAL OR INSTITUTION (If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <div style="font-size: 2em; margin-left: 20px;">00</div> <i>1622 Parkman Ave</i>		4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) A. STATE <i>Md.</i> B. COUNTY <span style="float: right;"><b>2582</b></span> C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> E. STREET AND NUMBER <i>1622 Parkman Ave Balto Md. 21230</i>			
5. SEX <i>M</i>	6. RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6/13/25</i>	9. AGE (In years lost birthday) <i>45</i>	If Under 1 Yr. Months: Days: Hours: Min. If Under 24 Hrs.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Foreman</i>		10B. KIND OF BUSINESS OR INDUSTRY <i>Glidden Paint Co</i>		11. BIRTHPLACE (State or foreign country) <i>Md.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>USA</i>		13. FATHER'S NAME <i>George Stumpf</i>		14. MOTHER'S MAIDEN NAME <i>Amelia Folks</i>	
15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <i>WW 2</i>		16. SOCIAL SECURITY NO. <i>212 20 0031</i>		17. INFORMANT ADDRESS <i>Clara P. Stumpf 1622 Parkman Ave 21230</i>	
18. <i>186X I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.		CAUSE OF DEATH (A) IMMEDIATE CAUSE (Malignant) <i>semimoma</i> <i>testicle with widespread</i> <i>abdominal spread including</i> <i>liver</i> (B) DUE TO, OR AS A CONSEQUENCE OF: (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).					
19A. DATE OF OPERATION		19B. CONDITION FOR WHICH OPERATION WAS PERFORMED		20A. AUTOPSY? (Yes or No)	
21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)		21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)	
21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I certify that (I) (this hospital) attended the deceased from <i>28 Dec</i> 19 <i>71</i> to <i>21 Jan</i> 19 <i>72</i> , that (I) <del>(we)</del> lost saw the deceased alive on <i>19 Jan</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) <del>(we)</del> <i>(did)</i> (did not) view the body after death.					
23A. SIGNATURE <i>Laurence R. Gallagher, M.D.</i>				23B. DATE SIGNED <i>24 Jan 72</i>	
23C. PHYSICIAN'S NAME (Type) Laurence R. Gallagher, M.D.				23D. ADDRESS 3455 Wilkens Avenue	
24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>		24B. DATE <i>1/25/72</i>		24C. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>	
24D. LOCATION (City, town, or county) (State) <i>Ritchie Hwy Baltimore Md. 21225</i>					
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>		25B. NAME OF REGISTRAR <i>John F. ...</i>		25C. FUNERAL DIRECTOR ADDRESS <i>McCall Funeral Home 237 Patapsco Ave 21225</i>	



G-120

72 00879

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00879

BIRTH NO.

1. NAME OF DECEASED (Type or Print) <b>Doris M. Gibbs</b>		2. DATE OF DEATH Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month <b>1</b> Day <b>20</b> Year <b>72</b> Hour <b>10:00 p.</b>	
4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) <b>40 St. Agnes Hospital</b>		3. DATE PRONOUNCED DEAD Month <b>1</b> Day <b>20</b> Year <b>72</b> Hour <b>10:00 p.</b>	
6. SEX <b>female</b>		7. RACE <b>White</b>	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		C. CITY OR TOWN <b>Balto.</b>	
9. DATE OF BIRTH <b>10-6-1925</b>		10. AGE (In years lost birthday) <b>46</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF <b>U.S.A.</b>	
13. FATHER'S NAME <b>Spencer Stout</b>		14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
15. MOTHER'S MAIDEN NAME <b>Birdie Bowen</b>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>	
17. SOCIAL SECURITY NO.		18. INFORMANT <b>Mr. Benjamin L. Gibbs, 626 Yale Ave. 21229</b>	
19. CAUSE OF DEATH <b>Pulmonary embolism</b>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)		(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:	
ANTECEDENT CAUSES DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.		(B) DUE TO, OR AS A CONSEQUENCE OF:	
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).			
20A. DATE OF OPERATION <b>2</b>		20B. CONDITION FOR WHICH OPERATION WAS PERFORMED	
21. AUTOPSY? (Yes or No) <b>yes</b>			
22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	
22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?			
22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)		22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
22F. HOW DID INJURY OCCUR?			
23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b> CHIEF MEDICAL EXAMINER <input type="checkbox"/> EXAMINER'S NAME (Type) <b>Peter Lipkovic, M.D.</b> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1/21/72</b>			
24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		24B. DATE <b>1-24-1972</b>	
24C. NAME OF CEMETERY or CREMATORY <b>Lorraine Park Cemetery</b>		24D. LOCATION (City, town, or county) (State) <b>Woodlawn, Maryland</b>	
25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>		25B. NAME OF REGISTRAR <b>Robert E. Vaden, R.D.</b>	
25C. FUNERAL DIRECTOR <b>Howard H. Hubbard, 4107 Wilkens Avenue</b>		25D. ADDRESS <b>21229</b>	

2000

1

— 199 —

100

• • • • •

35-36

11

10

Journal of Interpersonal Violence 22(12)

[illegible]

1. The first part of the document is a list of names and titles, including "The Hon. Mr. Justice" and "The Hon. Mr. Justice".

1. 2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22. 23. 24. 25. 26. 27. 28. 29. 30. 31. 32. 33. 34. 35. 36. 37. 38. 39. 40. 41. 42. 43. 44. 45. 46. 47. 48. 49. 50. 51. 52. 53. 54. 55. 56. 57. 58. 59. 60. 61. 62. 63. 64. 65. 66. 67. 68. 69. 70. 71. 72. 73. 74. 75. 76. 77. 78. 79. 80. 81. 82. 83. 84. 85. 86. 87. 88. 89. 90. 91. 92. 93. 94. 95. 96. 97. 98. 99. 100. 101. 102. 103. 104. 105. 106. 107. 108. 109. 110. 111. 112. 113. 114. 115. 116. 117. 118. 119. 120. 121. 122. 123. 124. 125. 126. 127. 128. 129. 130. 131. 132. 133. 134. 135. 136. 137. 138. 139. 140. 141. 142. 143. 144. 145. 146. 147. 148. 149. 150. 151. 152. 153. 154. 155. 156. 157. 158. 159. 160. 161. 162. 163. 164. 165. 166. 167. 168. 169. 170. 171. 172. 173. 174. 175. 176. 177. 178. 179. 180. 181. 182. 183. 184. 185. 186. 187. 188. 189. 190. 191. 192. 193. 194. 195. 196. 197. 198. 199. 200. 201. 202. 203. 204. 205. 206. 207. 208. 209. 210. 211. 212. 213. 214. 215. 216. 217. 218. 219. 220. 221. 222. 223. 224. 225. 226. 227. 228. 229. 230. 231. 232. 233. 234. 235. 236. 237. 238. 239. 240. 241. 242. 243. 244. 245. 246. 247. 248. 249. 250. 251. 252. 253. 254. 255. 256. 257. 258. 259. 260. 261. 262. 263. 264. 265. 266. 267. 268. 269. 270. 271. 272. 273. 274. 275. 276. 277. 278. 279. 280. 281. 282. 283. 284. 285. 286. 287. 288. 289. 290. 291. 292. 293. 294. 295. 296. 297. 298. 299. 300. 301. 302. 303. 304. 305. 306. 307. 308. 309. 310. 311. 312. 313. 314. 315. 316. 317. 318. 319. 320. 321. 322. 323. 324. 325. 326. 327. 328. 329. 330. 331. 332. 333. 334. 335. 336. 337. 338. 339. 340. 341. 342. 343. 344. 345. 346. 347. 348. 349. 350. 351. 352. 353. 354. 355. 356. 357. 358. 359. 360. 361. 362. 363. 364. 365. 366. 367. 368. 369. 370. 371. 372. 373. 374. 375. 376. 377. 378. 379. 380. 381. 382. 383. 384. 385. 386. 387. 388. 389. 390. 391. 392. 393. 394. 395. 396. 397. 398. 399. 400. 401. 402. 403. 404. 405. 406. 407. 408. 409. 410. 411. 412. 413. 414. 415. 416. 417. 418. 419. 420. 421. 422. 423. 424. 425. 426. 427. 428. 429. 430. 431. 432. 433. 434. 435. 436. 437. 438. 439. 440. 441. 442. 443. 444. 445. 446. 447. 448. 449. 450. 451. 452. 453. 454. 455. 456. 457. 458. 459. 460. 461. 462. 463. 464. 465. 466. 467. 468. 469. 470. 471. 472. 473. 474. 475. 476. 477. 478. 479. 480. 481. 482. 483. 484. 485. 486. 487. 488. 489. 490. 491. 492. 493. 494. 495. 496. 497. 498. 499. 500. 501. 502. 503. 504. 505. 506. 507. 508. 509. 510. 511. 512. 513. 514. 515. 516. 517. 518. 519. 520. 521. 522. 523. 524. 525. 526. 527. 528. 529. 530. 531. 532. 533. 534. 535. 536. 537. 538. 539. 540. 541. 542. 543. 544. 545. 546. 547. 548. 549. 550. 551. 552. 553. 554. 555. 556. 557. 558. 559. 560. 561. 562. 563. 564. 565. 566. 567. 568. 569. 570. 571. 572. 573. 574. 575. 576. 577. 578. 579. 580. 581. 582. 583. 584. 585. 586. 587. 588. 589. 590. 591. 592. 593. 594. 595. 596. 597. 598. 599. 600. 601. 602. 603. 604. 605. 606. 607. 608. 609. 610. 611. 612. 613. 614. 615. 616. 617. 618. 619. 620. 621. 622. 623. 624. 625. 626. 627. 628. 629. 630. 631. 632. 633. 634. 635. 636. 637. 638. 639. 640. 641. 642. 643. 644. 645. 646. 647. 648. 649. 650. 651. 652. 653. 654. 655. 656. 657. 658. 659. 660. 661. 662. 663. 664. 665. 666. 667. 668. 669. 670. 671. 672. 673. 674. 675. 676. 677. 678. 679. 680. 681. 682. 683. 684. 685. 686. 687. 688. 689. 690. 691. 692. 693. 694. 695. 696. 697. 698. 699. 700. 701. 702. 703. 704. 705. 706. 707. 708. 709. 710. 711. 712. 713. 714. 715. 716. 717. 718. 719. 720. 721. 722. 723. 724. 725. 726. 727. 728. 729. 730. 731. 732. 733. 734. 735. 736. 737. 738. 739. 740. 741. 742. 743. 744. 745. 746. 747. 748. 749. 750. 751. 752. 753. 754. 755. 756. 757. 758. 759. 760. 761. 762. 763. 764. 765. 766. 767. 768. 769. 770. 771. 772. 773. 774. 775. 776. 777. 778. 779. 780. 781. 782. 783. 784. 785. 786. 787. 788. 789. 790. 791. 792. 793. 794. 795. 796. 797. 798. 799. 800. 801. 802. 803. 804. 805. 806. 807. 808. 809. 810. 811. 812. 813. 814. 815. 816. 817. 818. 819. 820. 821. 822. 823. 824. 825. 826. 827. 828. 829. 830. 831. 832. 833. 834. 835. 836. 837. 838. 839. 840. 84

352

2-5

90, 0 - 0 127 101 , 13.74 . 20.5

T-520

72 00880

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00880

BIRTH NO.

REG. NO.

|   |                         |   |  |
|---|-------------------------|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>MELVIN RUSSELL THOMAS, SR.</b>  |                         | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> M.  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>532 Brunswick Street</b>   |                         | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>January 20, 1972 8:10 A.</b>   |  |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2006</b>   |                         |   |  |
| 6. SEX<br><b>Male</b>   | 7. RACE<br><b>White</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>12-3-1918</b>  |                         | 10. AGE (In years lost birthday) <b>53</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                         | 12. CITIZEN OF <b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>William Thomas</b>  |                         | 14. STREET AND NUMBER<br><b>532 Brunswick Street</b>  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Plumbers Helper</b>   |                         | 14B. KIND OF BUSINESS OR INDUSTRY   |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Carrie Meile</b>   |                         |   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes W W II</b>  |                         | 17. SOCIAL SECURITY NO.<br><b>215-09-1166</b>   |  |
| 18. INFORMANT<br><b>Mr. Melvin R. Thomas, Jr.</b>   |                         | ADDRESS <b>21223 2622 St. Benedicts S</b>   |  |
| 19. <b>4 12 4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b>   |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.  |                         | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:  |  |
|   |                         | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |
|   |                         | (C) DUE TO, OR AS A CONSEQUENCE OF:   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                         |   |  |
| 20A. DATE OF OPERATION<br><b>2</b>  |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?  |                         |   |  |
| 22D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |
| 22F. HOW DID INJURY OCCUR?  |                         |   |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |                         |   |  |
| ACTUAL SIGNATURE<br><b>Charles S. Springate, M.D.</b>   |                         | CHIEF MEDICAL EXAMINER <input type="checkbox"/>   |  |
| EXAMINER'S NAME (Type)  |                         | ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>  |  |
|   |                         | ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>1-24-1972</b>   |  |
| 24C. NAME of CEMETERY or CREMATORY<br><b>Mt. Olivet Cemetery</b>  |                         | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 26 1972</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Howard H. Hubbard</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>Howard H. Hubbard</b>   |                         | ADDRESS<br><b>4107 Wilkens Ave. 21229</b>   |  |

0880

0880

STANDARD CHARTER BANK

0880

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

STANDARD CHARTER BANK

B-355 72 00881 BALTIMORE CITY HEALTH DEPARTMENT  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO. 72 00881

|   |  |  |  |
|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JAMES R. BATEMAN</b>  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> Hour M.                        |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>CHURCH HOME AND HOSPITAL</b> |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br><b>January 23, 1972</b> Hour <b>1:05 A.M.</b>   |  |
| 6. SEX<br><b>Male</b>   |  | 7. RACE<br><b>White</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                             |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>203</b> |  |
| 9. DATE OF BIRTH<br><b>May 4 1933</b>   |  | 10. AGE (In years last birthday) <b>38</b><br>If Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.                                   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Amgerst Co. Va.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 13. FATHER'S NAME<br><b>Samuel W. Bateman</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>Phoebe L. Campbell</b>  |  |
| 15. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mechanic</b>   |  | 16. KIND OF BUSINESS OR INDUSTRY<br><b>White Motor Co.</b>   |  |
| 17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes Korean</b>  |  | 18. SOCIAL SECURITY NO.<br><b>225/36/2085</b>  |  |
| 19. INFORMANT<br><b>Mr. William Bateman (Brother)</b>   |  | ADDRESS<br><b>2607 Textile Drive, Gree-</b>  |  |

|  |  |   |  |
|--|--|---|--|
| 19. <b>E965X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |  | CAUSE OF DEATH<br><b>Gunshot wound of chest</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |  |

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 20A. DATE OF OPERATION<br><b>2</b>  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 21. AUTOPSY? (Yes or No)<br><b>yes</b>   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>Tavern</b>            |  | 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>2036 Eastern Avenue</b> |  |
| 22D. TIME OF INJURY (APPROX.)<br><b>1-23-72 12:10 A.M.</b>  |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> |  | 22F. HOW DID INJURY OCCUR?<br><b>Shot during altercation</b>   |  |

23. I certify that I held an Inquiry ☐ Inspection ☐ Autopsy ☒ and that on this basis, death in my opinion resulted from: Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☒ Undetermined manner ☐

ACTUAL SIGNATURE **Ronald N. Kornblum, M.D.** CHIEF MEDICAL EXAMINER ☐  
EXAMINER'S NAME (Type) **Ronald N. Kornblum, M.D.** ASSISTANT MEDICAL EXAMINER ☒ DATE SIGNED **1/23/72**  
ASSOCIATE MEDICAL EXAMINER ☐

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b> |  | 24B. DATE<br><b>1/26/72</b>                             |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Amherst Cemetery</b>           |  | 24D. LOCATION (City, town, or county) (State)<br><b>Amherst, Va.</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 26 1972</b>     |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b> |  | 25C. FUNERAL DIRECTOR<br><b>Singleton Funeral Home, Glen Burnie, Md</b> |  | ADDRESS<br><b>1700 W. Main</b>                                       |  |



12200/85

12200/85

X

X

NO. 1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000



72 00882

CERTIFICATE OF DEATH

REG. NO.

72 00882

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print)

Charles W. Kettle

2. DATE AND HOUR OF DEATH

1-23-72 1:00 P.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

Baltimore City Hospitals  
4940 Eastern Avenue  
Baltimore, Md. 21224

4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)  
A. STATE B. COUNTY

Maryland

Baltimore

C. CITY OR TOWN

D. INSIDE CITY LIMITS?

YES ☐

NO ☐

E. STREET AND NUMBER

202 Wagner Avenue 21221

5. SEX

Male

6. RACE

Caucasian

7. MARRIED ☐

NEVER MARRIED ☐

WIDOWED ☐

DIVORCED ☒

8. DATE OF BIRTH

5-30-1982

9. AGE (In years last birthday)

89

If Under 1 Yr. Months Days

If Under 24 Hrs. Hours Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

RETIRED CONCRETE FINISHER HAGERTOWN CITY

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

West Virginia

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John KETTLE

14. MOTHER'S MAIDEN NAME

UNK Albemarle

15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)

190

16. SOCIAL SECURITY NO.

220-09-7426

17. INFORMANT

Records: BCH-4940 Eastern Ave.

ADDRESS

21224

18.

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, osteonia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

CAUSE OF DEATH

Prostate Cancer

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

(B)

DUE TO, OR AS A CONSEQUENCE OF:

(C)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3 years

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

NO

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)

21E. INJURY OCCURRED

While At Work ☐

Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (this hospital) attended the deceased from 1-19 to 1-23-72 that (I) (we) last saw the deceased alive on 1-23-72 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Chu Shin Chiu

Attending Phys. ☒

Med. Director ☐

Staff Phys. ☐

23B. DATE SIGNED

1-23-72

23C. PHYSICIAN'S NAME (Type)

Chiu

23D. ADDRESS 4940 Eastern Ave., Baltimore, Md. 21224

24A. BURIAL CREMATION, REMOVAL (Specify)

BURIAL

24B. DATE

JAN 26 72

24C. NAME of CEMETERY or CREMATORY

MT CARMEL CEMETERY

24D. LOCATION

(City, town, or county) (State)

25A. DATE REC'D BY HEALTH DEPT.

JAN 26 1972

25B. NAME OF REGISTRAR

Robert E. Bailey, M.D.

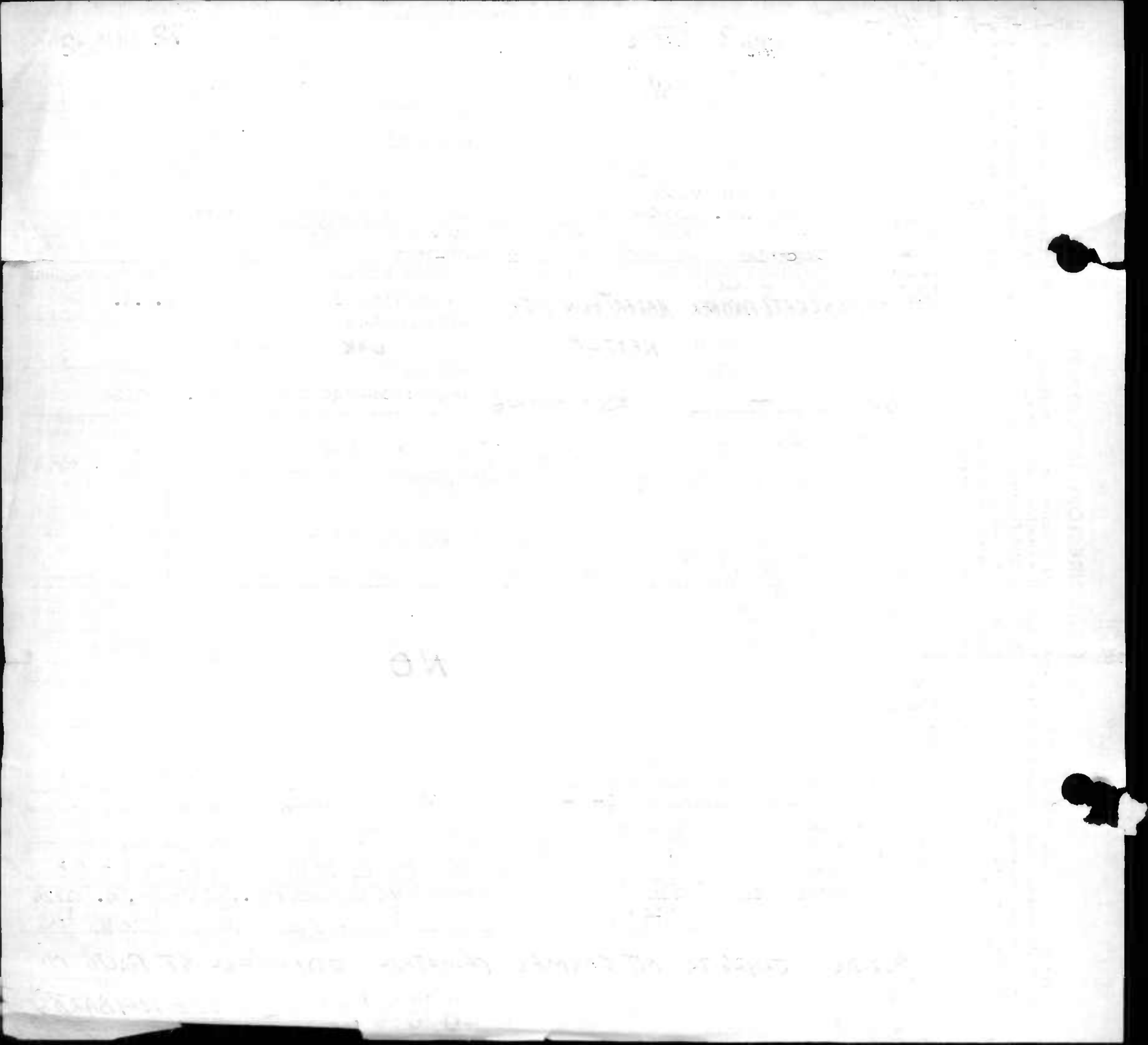
25C. FUNERAL DIRECTOR

DIPOPEL BROS INC 1601 E LOMBARD ST

ADDRESS

FUNERAL DIRECTOR: IMPORTANT

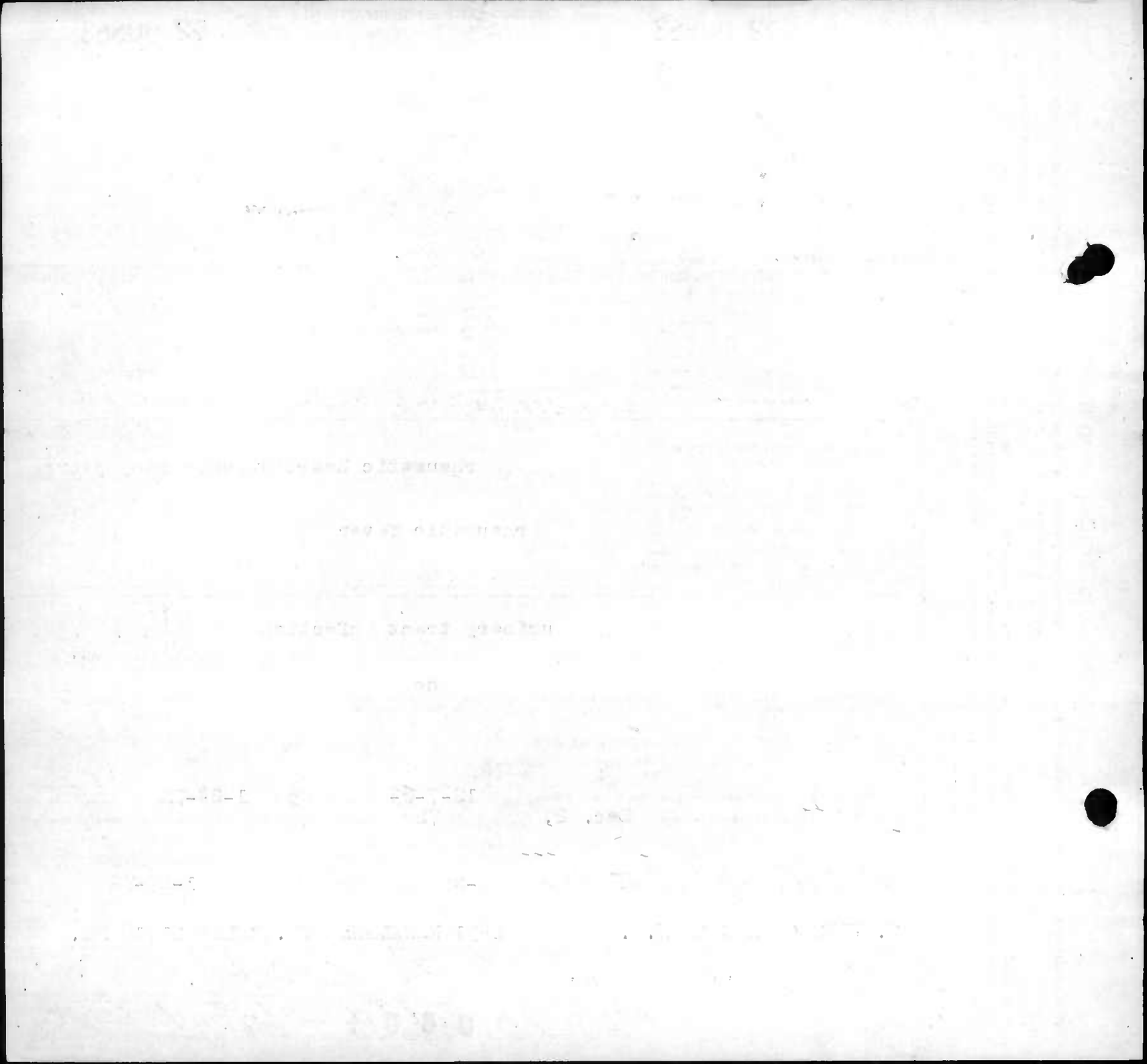
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                         |   |  |   |   |
|--|-------------------------|---|--|---|---|
| BIRTH NO. <b>M-245</b>   |                         | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <b>72 00883</b>                                      |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Edna M. Mc Lain</b>  |                         |   | 2. DATE AND HOUR OF DEATH<br><b>1/24/72</b>  |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                         |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Ind</b> B. COUNTY <b>1538</b> |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>00 3409 Fairview Ave.</b>  |                         |   | C. CITY OR TOWN<br><b>Balto.</b>   |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|  |                         |   | E. STREET AND NUMBER<br><b>3409 Fairview Ave.</b>  |   |   |
| 5. SEX<br><b>Female</b>  | 6. RACE<br><b>Cauc.</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8/14/04</b>   | 9. AGE (In years last birthday)<br><b>67</b>                  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.                                     |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br>—  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Pa.</b>       |   |
| 13. FATHER'S NAME<br><b>?</b>  |                         |   | 14. MOTHER'S MAIDEN NAME<br><b>?</b>   |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                         | 16. SOCIAL SECURITY NO.<br><b>218-03-6698</b>   |  | 17. INFORMANT ADDRESS<br><b>Edna C. Mc Lain (Same)</b>        |   |
| 18. <b>398X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br><b>rheumatic heart disease many years</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br><b>urinary tract infection</b> |                         |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |   |   |
| 19A. DATE OF OPERATION   |                         |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)<br><b>no</b>  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                         |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)                   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         |   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                          |   | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>12-7-65</b> 19 <b>65</b> to <b>1-24-72</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>Dec. 2,</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |   |  |   |   |
| 23A. SIGNATURE<br><b>E. Ellsworth Cook M.D.</b>  |                         |   |  | 23B. DATE SIGNED<br><b>1-25-72</b>                            |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>E. ELLSWORTH COOK M.D.</b>  |                         |   |  | 23D. ADDRESS<br><b>2431 MARYLAND AVE. BALTO 21218 Md.</b>     |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>1/27/72</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Gardens of Faith</b> |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Ind.</b>  |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 26 1972</b>   |  |   |   |
| 25B. NAME OF REGISTRAR<br><b>John F. [unclear]</b>   |                         | 25C. FUNERAL DIRECTOR ADDRESS<br><b>3617 Chestnut Ave.</b>  |  |   |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| Baltimore City Health Department<br>CERTIFICATE OF DEATH  |  |  |  |
|---|--|--|--|
| S-100<br>72 00884   |  | 72 00884   |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br><i>Vera Shopf</i>   |  | 2. DATE AND HOUR OF DEATH<br><i>21-Jan-72</i> <i>3:50</i> P.M.   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>South Balt. Gen. Hosp.</i>  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <i>Md.</i> B. COUNTY <i>2544</i>   |  |
| 5. SEX <i>Female</i> 6. RACE <i>White</i> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <i>2-22-19</i> 9. AGE (In years last birthday) <i>52</i>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>  |  | 11. BIRTHPLACE (State or foreign country) <i>Md.</i>   |  |
| 10B. KIND OF BUSINESS OR INDUSTRY <i>House wife</i>   |  | 12. CITIZEN OF WHAT COUNTRY? <i>USA</i>  |  |
| 13. FATHER'S NAME <i>George Ruby</i>  |  | 14. MOTHER'S MAIDEN NAME <i>Margaret Corbit</i>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <i>219 14 9616</i>   |  |
| 17. INFORMANT <i>Husband - George J. Shopf-Same</i>   |  | ADDRESS  |  |
| 18. <i>571.01</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <i>Alcoholic Liver Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <i>Chronic Alcoholism</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>YRS.</i><br><i>YRS.</i>   |  |
| 19A. DATE OF OPERATION <i>21</i>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20A. AUTOPSY? (Yes or No) <i>Yes</i>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>20-Jan-1977</i> to <i>21-Jan-1977</i> that (I) (we) lost saw the deceased alive on <i>21-Jan-1977</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.                   |  |  |  |
| 23A. SIGNATURE <i>Richard E. Fisher M.D.</i>  |  | 23B. DATE SIGNED <i>21-Jan-72</i>  |  |
| 23C. PHYSICIAN'S NAME (Type) <i>Richard E. Fisher M.D.</i>  |  | 23D. ADDRESS <i>South Balt. Gen. Hosp.</i>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>  |  | 24B. DATE <i>1/25/72</i>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cemetery</i>   |  | 24D. LOCATION (City, town, or county) (State) <i>Ritchie Hwy. Balto Md. 21225</i>  |  |
| 25A. DATE REC'D BY HEALTH DEPT. <i>JAN 26 1972</i>  |  | 25B. NAME OF REGISTRAR <i>Robert E. Fisher</i>   |  |
| 25C. FUNERAL DIRECTOR <i>McGully Funeral Home</i>   |  | ADDRESS <i>237 Patapsco Ave 21225</i>  |  |



B-362

72 00885

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00885

BIRTH NO.

REG. NO.

|   |  |  |   |  |
|---|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>Jay B. Badder   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month 1 Day 22 Year 72         |   | Hour   |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>Balto. City Hospital  |  | 3. DATE PRONOUNCED DEAD<br>Month 1 Day 22 Year 72  |   | Hour 2:02 a.m.   |
| 6. SEX<br>male  |  | 7. RACE<br>White   | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |
| 9. DATE OF BIRTH<br>Nov. 22, 1944   |  | 10. AGE (In years last birthday)<br>27   | 11. BIRTHPLACE (State or foreign country)<br>Balto. Md.   |  |
| 12. CITIZEN OF WHAT COUNTRY<br>U.S.A.   |  | 13. FATHER'S NAME<br>Andrew J. Badders   |   | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Erector                                |
| 15. MOTHER'S MAIDEN NAME<br>Katherine Brodka  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give year or dates of service)<br>Yes 1965-1968          |   | 17. SOCIAL SECURITY NO.<br>218-44-3228   |
| 18. INFORMANT<br>Andrew J. Brodka   |  | 19. CAUSE OF DEATH<br>Multiple injuries  |   | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |
| 21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |  | 22. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |   | 23. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |
| 24. DATE OF OPERATION<br>2  |  | 25. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 26. AUTOPSY? (Yes or No)<br>yes  |
| 27. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 28. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Street                                  |   | 29. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>Liberty Pkwy. 250 ft. E. of Lee Avenue, Dundalk           |
| 30. TIME OF INJURY (APPROX.)<br>1 22 72 1:36 a.m.   |  | 31. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>                |   | 32. HOW DID INJURY OCCUR?<br>Subject driver of car - lost control (one car accident)   |
| 33. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  | 34. ACTUAL SIGNATURE<br>Ronald N. Kornblum, M.D.   |   | 35. DATE SIGNED<br>1/22/72   |
| 36. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |  | 37. DATE<br>1-25-72  |   | 38. NAME OF CEMETERY or CREMATORY<br>Parkwood Cemetery   |
| 39. DATE REC'D BY HEALTH DEPT.<br>JAN 26 1972   |  | 40. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.  |   | 41. FUNERAL DIRECTOR<br>John C. Miller Inc-6415 Belair Road-21206  |
| 42. ADDRESS<br>Baltimore, Maryland  |  | 43. ADDRESS<br>Baltimore, Maryland   |   | 44. ADDRESS<br>Baltimore, Maryland   |

2-3-1972 - Completion of cause of death on a pending medical examiner death certificate  
Ronald N. Kornblum, M.D.

HRS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |  |
|---|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <b>72 00886</b>  |  |
| BIRTH NO. <b>B-652</b>  |  | 72 00886  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>BARNES, CUSTUS ELIZABETH</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>JANUARY 20, 1972 10:05 P.M.</b>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>CARROLL</b> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>ST AGNES HOSPITAL<br/>CATON &amp; WILKENS AVENUES<br/>BALTIMORE, MARYLAND 21229</b>  |  | C. CITY OR TOWN <b>SYKESVILLE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>              |  |
| 5. SEX <b>FEMALE</b> 6. RACE <b>CAUCASIAN</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>02/10/80</b> 9. AGE (In years last birthday) <b>91</b>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>  |  | 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>   |  |
| 10B. KIND OF BUSINESS OR INDUSTRY <b>home</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>  |  |
| 13. FATHER'S NAME <b>FRANK RAWLINGS</b>   |  | 14. MOTHER'S MAIDEN NAME <b>MISS ALLEN, MARY JANE</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>NO</b>  |  | 16. SOCIAL SECURITY NO. <b>?</b>  |  |
| 17. INFORMANT <b>Leslie A. Barnes,</b>  |  | ADDRESS <b>same as # 4</b>  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Complete heart block</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr.</b>  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Acute inferior M.I.</b>  |  |
|   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |
|   |  | (C) _____   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  | <b>Co of @ breast</b>   |  |
| 19A. DATE OF OPERATION <b>1/10/72</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>3 yrs</b>   |  |
| 20A. AUTOPSY? (Yes or No) <b>NO</b>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                    |  |
| 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JANUARY 20</b> 19 <b>72</b> to <b>JANUARY 22</b> 19 <b>72</b> that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>JANUARY 22</b> 19 <b>72</b> and that <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. |  |   |  |
| 23A. SIGNATURE <b>JOSE APTER, M.D.</b>  |  | 23B. DATE SIGNED <b>01/23/72</b>  |  |
| 23C. PHYSICIAN'S NAME (Type) <b>JOSE APTER, M.D.</b>  |  | 23D. ADDRESS <b>BALTO MD 21229 ST AGNES HOSPITAL CATON &amp; WILKENS AVES</b>   |  |
| 24A. BURIAL-CREATION, REMOVAL (Specify) <b>BURIAL</b>   |  | 24B. DATE <b>1-26-1972</b>  |  |
| 24C. NAME OF CEMETERY or CREMATORY <b>MESSIAH LUTHERAN</b>  |  | 24D. LOCATION (City, town, or county) (State) <b>CARROLL MD.</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>  |  | 25B. NAME OF REGISTRAR <b>C.M. WALTZ,</b>   |  |
| 25C. FUNERAL DIRECTOR ADDRESS <b>Box 326, Sykesville, Md.</b>   |  |   |  |

10:00 P.M. 10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M. 10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M.

10:00 P.M. 10:00 P.M.

10:00 P.M.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH

REG. NO.

72-00887

BIRTH NO.

72 00887

1. NAME OF DECEASED

(Type or Print)

ARTHUR JACKSON

2. DATE AND HOUR OF DEATH

JANUARY 22 1972 7:40 A.M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

FULL NAME OF HOSPITAL OR INSTITUTION

(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)

34 Bon Secours Hospital

4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)

A. STATE B. COUNTY

MARYLAND

C. CITY OR TOWN

BALTIMORE

D. INSIDE CITY LIMITS?

YES ☒

NO ☐

E. STREET AND NUMBER

1019 W. LEXINGTON STREET

5. SEX

MALE

6. RACE

NEGRO

7. MARRIED ☒

NEVER MARRIED ☐

WIDOWED ☐

SEPARATED ☐ DIVORCED ☐

8. DATE OF BIRTH

9/24/19

9. AGE (In years last birthday)

32

If Under 1 Yr. Months

If Under 1 Yr. Days

If Under 24 Hrs. Hours

Min.

10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LONGSHOREMAN

10B. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

ARTHUR JACKSON

14. MOTHER'S MAIDEN NAME

Mary Jackson

15. Was Deceased Ever in U. S. Armed Forces?

(Yes, no or unknown)

Yes

WW2

16. SOCIAL SECURITY NO.

212-14-1341

17. INFORMANT

Mary Jones 221 N. Schroeder St.

ADDRESS

18. 485 X 1

CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE

DUE TO, OR AS A CONSEQUENCE OF:

Septicemia

(B) DUE TO, OR AS A CONSEQUENCE OF:

Empyema

(C) DUE TO, OR AS A CONSEQUENCE OF:

Cough. Bronchopneumonia

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

week

week

month

MEDICAL CERTIFICATION

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).

19A. DATE OF OPERATION

19B. CONDITION FOR WHICH OPERATION WAS PERFORMED

20A. AUTOPSY? (Yes or No)

20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)

21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

21C. WHERE DID INJURY OCCUR?

(If in Baltimore City, give exact location)

21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)

21E. INJURY OCCURRED

While At Work ☐ Not While At Work ☐

21F. HOW DID INJURY OCCUR?

22. I certify that (I) (this hospital) attended the deceased from \_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_ that (I) (we) last saw the deceased alive on \_\_\_\_\_ 19\_\_\_\_ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE

Ricardo M. Valbonesi M.D.

Attending Phys. ☐

Med. Director ☐

Staff Phys. ☒

23B. DATE SIGNED

1-22-72

23C. PHYSICIAN'S NAME (Type)

23D. ADDRESS

Bon Secours Hospital

24A. BURIAL CREMATION, REMOVAL (Specify)

24B. DATE

24C. NAME OF CEMETERY or CREMATORY

24D. LOCATION (City, town or county)

(State)

25A. DATE REC'D BY HEALTH DEPT

25B. NAME OF REGISTRAR

25C. FUNERAL DIRECTOR

ADDRESS

JAN 26 1972

Robert E. Taylor, R.D.

William's Funeral Home 399 N. Schroeder St.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Frank White</b>   |  |  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month <b>1</b> Day <b>20</b> Year <b>72</b> Hour <b>M.</b>         |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>38 University Hospital</b>   |  |  |  | 3. DATE PRONOUNCED DEAD<br>Month <b>1</b> Day <b>20</b> Year <b>72</b> Hour <b>3:00p.</b> M.   |  |
| 6. SEX<br><b>male</b>   |  | 7. RACE<br><b>White</b>  |  | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br><b>Oct 11 - 1890</b>  |  | 10. AGE (In years last birthday)<br><b>82</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  | 13. FATHER'S NAME<br><b>Manfield White</b>   |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Farmer</b>  |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Ella Whitmore</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 17. SOCIAL SECURITY NO.<br><b>220-34-7760</b>  |  |
| 18. INFORMANT<br><b>Mrs. Albert Chabin</b>  |  | 19. CAUSE OF DEATH<br><b>Multiple injuries</b>   |  | 20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 21. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | 22. IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:   |  | 23. DUE TO, OR AS A CONSEQUENCE OF:  |  |
| 24. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  | 25. DUE TO, OR AS A CONSEQUENCE OF:  |  | 26. DUE TO, OR AS A CONSEQUENCE OF:  |  |
| 27. DATE OF OPERATION<br><b>2</b>   |  | 28. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 29. AUTOPSY? (Yes or No)<br><b>yes</b>   |  |
| 30. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH.   |  | 31. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>STREET</b>   |  | 32. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>Broadway and Madison St. (Frederick)</b>   |  |
| 33. TIME (Month) (Day) (Year) (Hour) (Approx.)<br><b>1 20 72 11:57 a.m.</b>   |  | 34. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>  |  | 35. HOW DID INJURY OCCUR?<br><b>Subject driver in auto/auto collision.</b>   |  |
| 23. I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |  |  |  |  |
| ACTUAL SIGNATURE<br>EXAMINER'S NAME (Type)<br><b>Peter Lipkovic, M.D.</b>   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  | DATE SIGNED<br><b>1/21/72</b>  |  |
| 36. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 37. DATE<br><b>1/24/72</b>   |  | 38. NAME OF CEMETERY or CREMATORY<br><b>Mt. Olivet</b>   |  |
| 39. LOCATION (City, town, or county) (State)<br><b>Frederick Maryland</b>   |  | 40. DATE REC'D BY HEALTH DEPT.<br><b>JAN 26 1972</b>   |  | 41. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |  |
| 42. FUNERAL DIRECTOR<br><b>Hilton Funeral Home</b>  |  | 43. ADDRESS<br><b>Danversville</b>   |  | 44. VS 151-REV. 1/1/68   |  |

28 10000

10000

10000

10000

10000

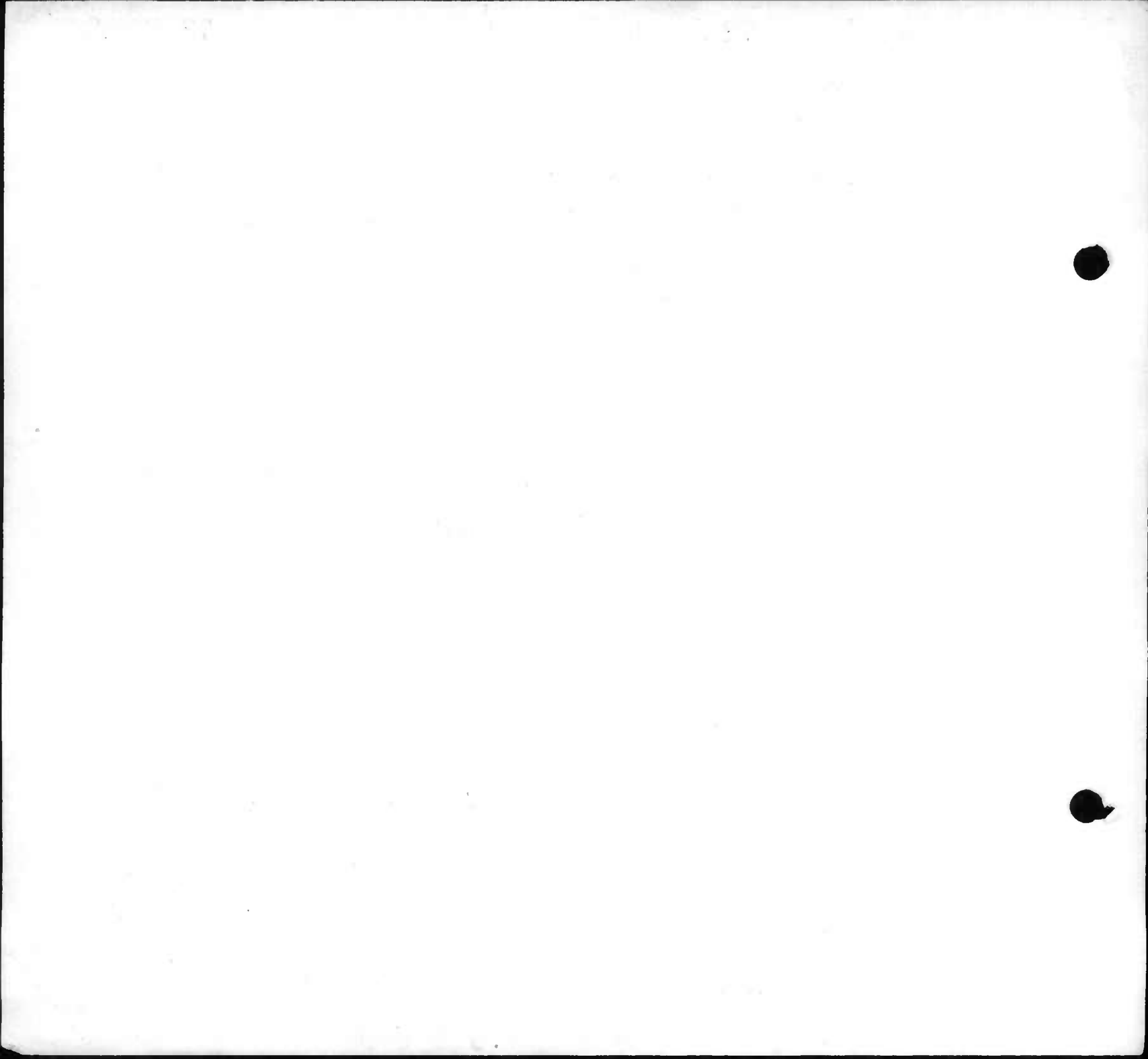
10000

10000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |  |
|--|--|---|--|
| <div style="display: flex; justify-content: space-between;"> <span>B-623</span> <span>72 00889</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>   |  | REG. NO. <span style="font-size: 1.2em;">72 00889</span>  |  |
| BIRTH NO. <span style="font-size: 1.2em;">1</span>   |  | 2. DATE AND HOUR OF DEATH<br><div style="display: flex; justify-content: space-between;"> <span>1/14/72</span> <span>940 P.M.</span> </div>   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">THOMAS BRAXTON</span>   |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><div style="display: flex; justify-content: space-between;"> <div>           FULL NAME OF HOSPITAL OR INSTITUTION<br/> <span style="font-size: 1.2em;">University of Maryland Hospital</span><br/> <span style="font-size: 1.2em;">822 S. Green St.</span> </div> <div>           (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)         </div> </div>  |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <span style="font-size: 1.2em;">MD</span> B. COUNTY <span style="font-size: 1.2em;">402</span>   |  | C. CITY OR TOWN <span style="font-size: 1.2em;">Baltimore</span> D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 5. SEX <span style="font-size: 1.2em;">M</span> 6. RACE <span style="font-size: 1.2em;">N</span> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <span style="font-size: 1.2em;">3-3-05</span> 9. AGE (in years last birthday) <span style="font-size: 1.2em;">66</span>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">-</span>   |  | 10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">-</span>  |  |
| 11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">-</span>   |  | 12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">US</span>  |  |
| 13. FATHER'S NAME <span style="font-size: 1.2em;">-</span>   |  | 14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">-</span>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">-</span>  |  | 16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">-</span>  |  |
| 17. INFORMANT <span style="font-size: 1.2em;">-</span>   |  | ADDRESS <span style="font-size: 1.2em;">-</span>  |  |
| 18. <span style="font-size: 1.2em;">319.21</span> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                                 |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><div style="display: flex; justify-content: space-between;"> <div>           (A) IMMEDIATE CAUSE<br/>           DUE TO, OR AS A CONSEQUENCE OF:<br/> <span style="font-size: 1.2em;">Cardiac arrest</span> </div> <div>           (B) <span style="font-size: 1.2em;">Chronic pulmonary &amp; liver disease</span><br/>           DUE TO, OR AS A CONSEQUENCE OF:<br/> <span style="font-size: 1.2em;">-</span> </div> <div>           (C) <span style="font-size: 1.2em;">-</span> </div> </div> |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><span style="font-size: 1.2em;">II</span>  |  |   |  |
| 19A. DATE OF OPERATION <span style="font-size: 1.2em;">-</span>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <span style="font-size: 1.2em;">-</span>   |  |
| 20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">-</span>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <span style="font-size: 1.2em;">-</span>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <span style="font-size: 1.2em;">No</span>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) <span style="font-size: 1.2em;">-</span>   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <span style="font-size: 1.2em;">-</span>  |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) <span style="font-size: 1.2em;">-</span>  |  |
| 21E. INJURY OCCURRED <span style="font-size: 1.2em;">-</span>  |  | 21F. HOW DID INJURY OCCUR? <span style="font-size: 1.2em;">-</span>   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">12/25/71</span> 19 to <span style="font-size: 1.2em;">1/14/72</span> 19<br>that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">1/14/72</span> 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |
| 23A. SIGNATURE <span style="font-size: 1.2em;">[Signature]</span>  |  | 23B. DATE SIGNED <span style="font-size: 1.2em;">1/14/72</span>   |  |
| 23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">SONACHARON</span>   |  | 23D. ADDRESS <span style="font-size: 1.2em;">ANATOMY BOARD OF MARYLAND</span>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">1-21-72</span>  |  | 24B. DATE <span style="font-size: 1.2em;">1-21-72</span>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">UNIVERSITY MEDICAL SCHOOL</span>  |  | 24D. LOCATION (City, State or county) (State) <span style="font-size: 1.2em;">-</span>  |  |
| 25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 26 1972</span>   |  | 25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">[Signature]</span>   |  |
| 25C. FUNERAL DIRECTOR <span style="font-size: 1.2em;">MORTUARY SERVICE - BCUH</span>   |  | ADDRESS <span style="font-size: 1.2em;">-</span>  |  |



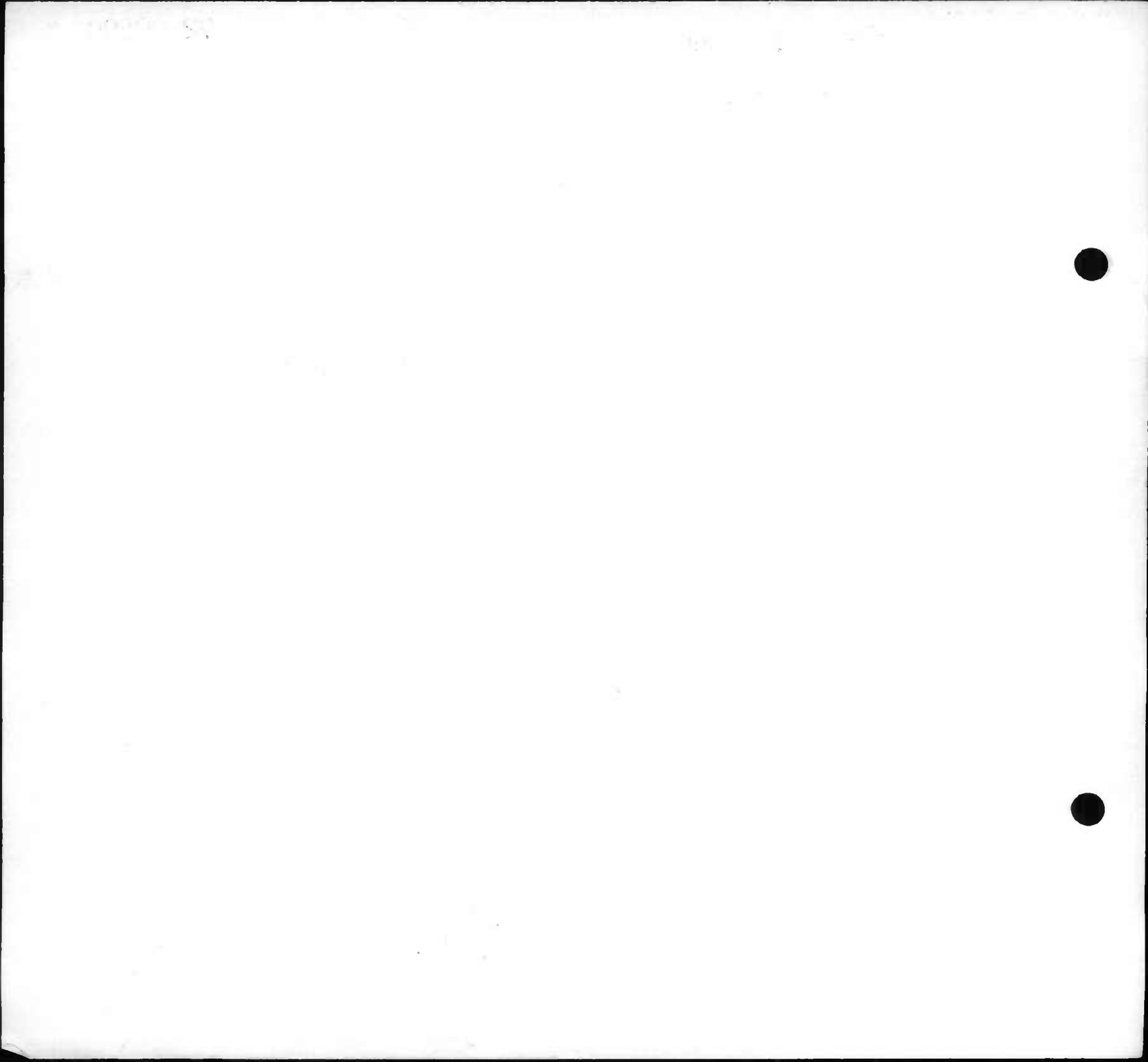


# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |   |  | REG. NO. <b>72 00890</b>   |  |
|--|--|---|--|--|--|
| CERTIFICATE OF DEATH   |  |   |  |  |  |
| BIRTH NO. <b>5-152 72 00890</b>  |  | 1. NAME OF DECEASED<br>(Type or Print) <b>Baby Boy Spence</b>   |  |  |  |
| 2. DATE AND HOUR OF DEATH<br><b>1/11/72</b>  |  | 12 <sup>30</sup> A.M.   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>907</b> |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>38 University of Maryland Hosp.</b>   |  | C. CITY OR TOWN<br><b>Balt.</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 5. SEX<br><b>M</b>   |  | 6. RACE<br><b>Negro</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><b>1/10/72</b>   |  | 9. AGE (In years last birthday)   |  | 10. UNDER 1 Yr. Months <b>11</b> Days <b>45</b>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)  |  |
| 13. FATHER'S NAME<br><b>Earl Wendell Spence</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Debra Spence</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
| 18. <b>777X I</b>  |  | CAUSE OF DEATH  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Immaturity</b>  |  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  |  |  |
| (C)  |  |   |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |  |  |  |
| 19A. DATE OF OPERATION<br><b>2</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No) <b>YES</b>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                         |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>1/10</b> <b>19 72</b> to <b>1/11</b> <b>19 72</b> that (1) (we) last saw the deceased alive on <b>1/11</b> <b>19 72</b> and that (1) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |  |   |  |  |  |
| 23A. SIGNATURE<br><b>James A. Kopper MD</b>  |  | 23B. DATE SIGNED  |  | 23C. PHYSICIAN'S NAME (Type)<br><b>James A. Kopper MD</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  | 24B. DATE<br><b>1-24-72</b>   |  | 24C. NAME OF CEMETERY or CREMATORY   |  |
| 25A. DATE REC'D BY HEALTH DEPT.  |  | 25B. NAME OF REGISTRAR  |  | 25C. FUNERAL DIRECTOR  |  |
| 26A. DATE REC'D BY HEALTH DEPT.  |  | 26B. NAME OF REGISTRAR  |  | 26C. FUNERAL DIRECTOR  |  |

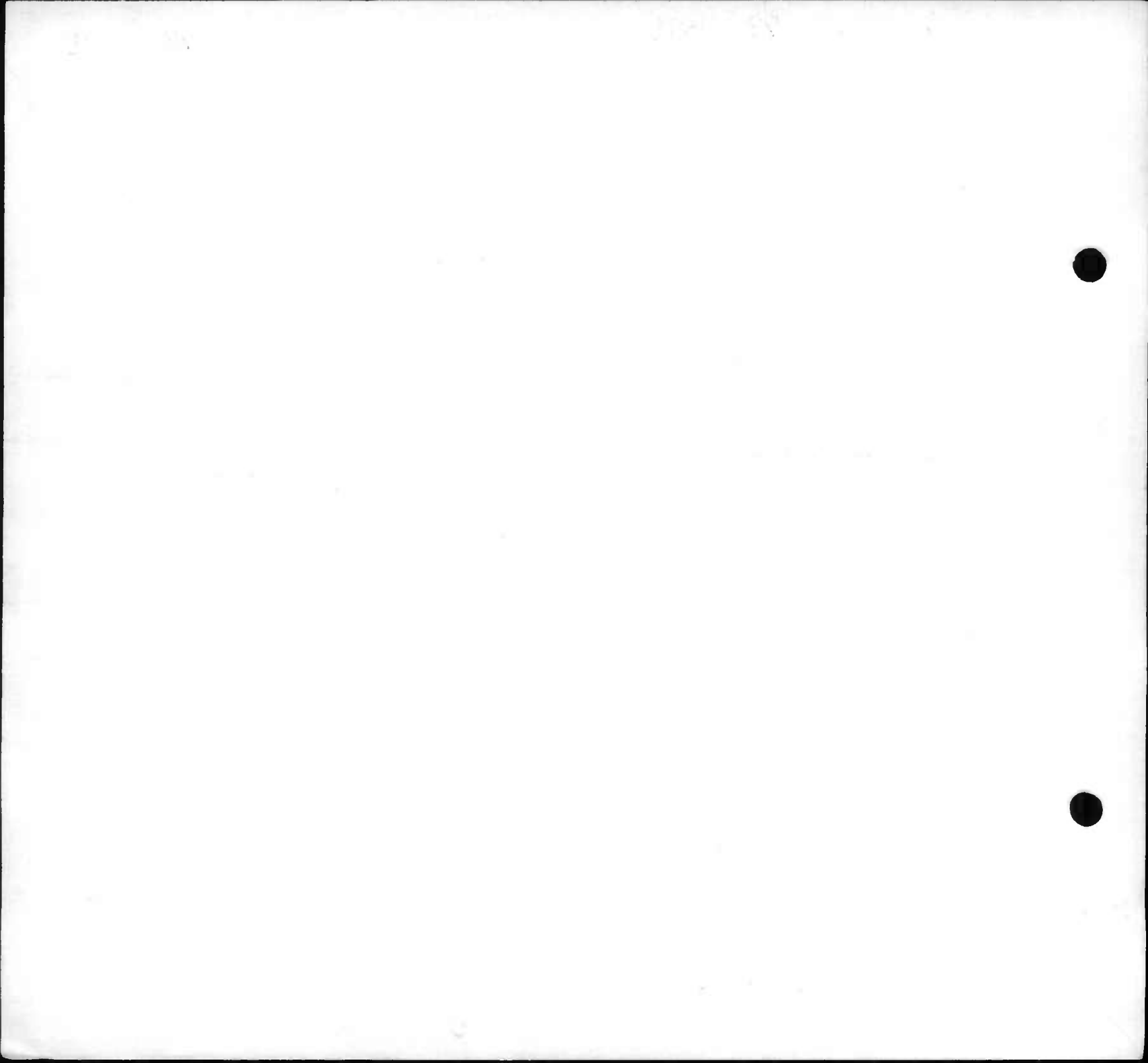
**ANATOMY BOARD OF MARYLAND**  
**UNIVERSITY MEDICAL SCHOOL**  
**MORTUARY SERVICE - BCHD**



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

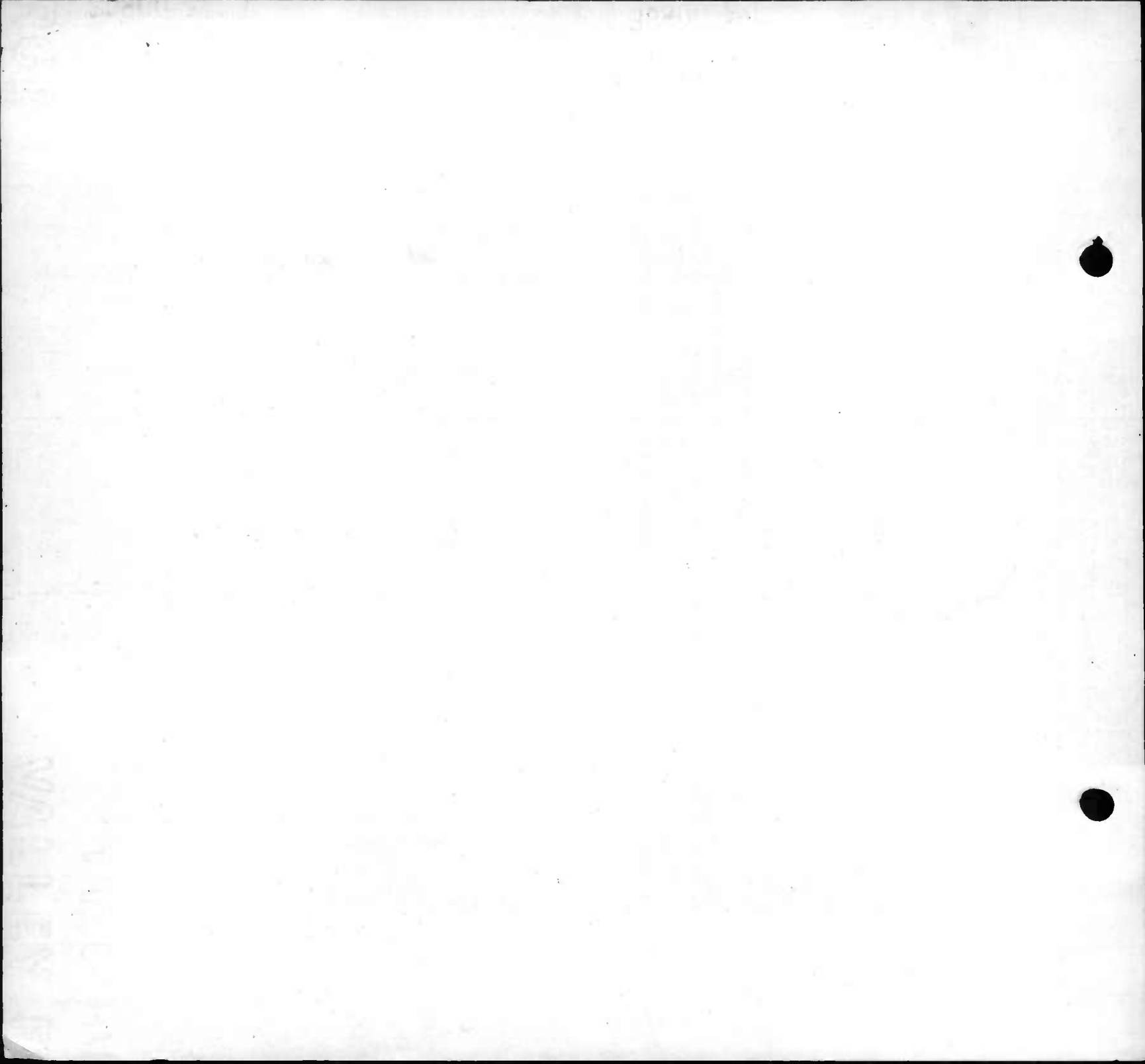
|  |                  |  |  |  |   |
|--|------------------|--|--|--|---|
| <div style="display: flex; justify-content: space-between;"> <span><b>D-120</b></span> <span><b>72 00891</b></span> </div>   |                  | <b>BALTIMORE CITY HEALTH DEPARTMENT</b><br><b>CERTIFICATE OF DEATH</b>   |  | REG. NO. <b>72 00891</b>   |   |
| BIRTH NO. <b>72-00719</b><br>1. NAME OF DECEASED<br>(Type or Print) <b>Baby Boy Davis</b>  |                  | 2. DATE AND HOUR OF DEATH<br><b>1/14/72</b> <b>1 10<sup>30</sup> A.M.</b>  |  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>University of Maryland Hospital</b><br><b>38</b>   |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>md.</b> B. COUNTY <b>1703</b><br>5. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>6. STREET AND NUMBER <b>800 Harlem Ave</b> <b>21201</b> |  |  |   |
| 5. SEX <b>M</b>  | 6. RACE <b>N</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>1/14/72</b>  | 9. AGE (in years last birthday)<br>10. Under 1 Yr. Months: Days: Hours: Min. <b>7</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>                |   |
| 13. FATHER'S NAME <b>Matthew Austin</b>  |                  | 14. MOTHER'S MAIDEN NAME <b>Cynthia Davis</b>  |  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT <b>Hosp. record</b> ADDRESS                                |   |
| 18. <b>77201</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Respiratory Distress Syndrome</b><br><b>Antecedent Causes</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                    |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Respiratory Distress Syndrome</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>intra-cranial hemorrhage</b><br><b>Cerebral</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Prematurity</b><br>(C)  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |   |
| 19. DATE OF OPERATION <b>2</b>   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No) <b>Yes</b>                                     |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.)  |                  | 21E. INJURY OCCURRED<br>White At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that <del>it</del> (this hospital) attended the deceased from <b>1/14 3 AM</b> 19 <b>72</b> to <b>1/14 10<sup>30</sup> AM</b> 19 <b>72</b> that <del>it</del> (we) last saw the deceased alive on <b>1/14</b> 19 <b>72</b> and that <del>in</del> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <del>It</del> (We) (did) (did not) view the body after death. |                  |  |  |  |   |
| 23A. SIGNATURE <b>James A. Kopper MD</b>   |                  | 23B. DATE SIGNED <b>1/14/72</b>  |  | 23C. PHYSICIAN'S NAME (Type) <b>James A. Kopper MD</b>                   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>1-24-72</b>  |                  | 24B. DATE  |  | 24C. NAME of CEMETERY or CREMATORY                                       |   |
| 25A. DATE REC'D BY HEALTH DEPT. <b>JAN 26 1972</b>   |                  | 25B. NAME OF REGISTRAR <b>Robert E. Fisher MD</b>  |  | 25C. FUNERAL DIRECTOR <b>MORTUARY SERVICE - BCHD</b> ADDRESS             |   |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |   |   |  |   |   |  |  |   |  |
|---|-------------------------|---|---|--|---|---|--|--|---|--|
| N-400 12 00892  |                         |   |   |  | REG. NO. 12 00892   |   |  |  |   |  |
| BIRTH NO.   |                         |   |   |  | CERTIFICATE OF DEATH  |   |  |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Esther Margaret Neal</i>  |                         |   |   |  | 2. DATE AND HOUR OF DEATH<br><i>1-26-72 8:15 a.m.</i>   |   |  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         |   |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |   |  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><i>Good Samaritan Hospital</i><br><i>45</i>   |                         |   |   |  | A. STATE<br><i>MARYLAND</i><br>B. COUNTY<br><i>2748</i>   |   |  |  |   |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                         |   |   |  | C. CITY OR TOWN<br><i>BALTIMORE City</i><br>D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |  |  |   |  |
| E. STREET AND NUMBER<br><i>1230 COCHRAN AVE.</i>  |                         |   |   |  |   |   |  |  |   |  |
| 5. SEX<br><i>Female</i>   | 6. RACE<br><i>Negro</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Oct. 13, 1920</i>  | 9. AGE (In years last birthday)<br><i>51</i> | If Under 1 Yr. Months: Days: Hours: Min.  |   | If Under 24 Hrs. Hours: Min.                           |  |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Hospital</i>  |                         |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Medical</i>   |  |   | 11. BIRTHPLACE (State or foreign country)<br><i>Virginia</i>                |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>                               |  |
| 13. FATHER'S NAME<br><i>Robert Wise</i>   |                         |   |   |  | 14. MOTHER'S MAIDEN NAME<br><i>ELLA STOKES</i>  |   |  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>Unknown</i>  |                         |   |   |  | 16. SOCIAL SECURITY NO.<br><i>224-26-6787</i>   |   | 17. INFORMANT<br><i>Samuel Neal- 1230 Cochran Ave.</i> |  |   |  |
| 18. <i>162.1 I</i>  |                         |   |   |  | CAUSE OF DEATH  |   |  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><i>Cardiorespiratory arrest</i>   |                         |   |   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:  |   |  |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         |   |   |  | (B) <i>metastatic bronchogenic CA</i><br>DUE TO, OR AS A CONSEQUENCE OF:  |   |  |  |   |  |
| (C).....  |                         |   |   |  |   |   |  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |   |   |  |   |   |  |  |   |  |
| 19A. DATE OF OPERATION<br><i>0</i>  |                         |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   | 20A. AUTOPSY? (Yes or No)<br><i>No</i>                                      |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                         |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  |   | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         |   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  |   | 21F. HOW DID INJURY OCCUR?  |  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>1-14</i> 19 <i>72</i> to <i>1-26</i> 19 <i>72</i> , that (I) (we) last saw the deceased alive on <i>1-25</i> 19 <i>72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |   |  |   |   |  |  |   |  |
| 23A. SIGNATURE<br><i>Larry Kvoles MD</i>  |                         |   |   |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>           |   |  | 23B. DATE SIGNED<br><i>1-26-72</i>                                   |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>LARRY Kvoles MD</i>  |                         |   |   |  | 23D. ADDRESS<br><i>Johns Hopkins Hospital</i>   |   |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Removal-Burial</i>   |                         |   | 24B. DATE<br><i>1/30/72</i>   |  |   | 24C. NAME OF CEMETERY or CREMATORY<br><i>Mercy See Baptist</i>              |  |  | 24D. LOCATION (City, town, or county) (State)<br><i>Farmville, Virginia</i> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>JAN 27 1972</i>   |                         |   | 25B. NAME OF REGISTRAR<br><i>Robert E. Kelly, Jr.</i>   |  |   | 25C. FUNERAL DIRECTOR<br><i>Marshall W. Jones, Jr.</i>                      |  |  | ADDRESS<br><i>1735 Harford Ave.</i>   |  |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <span style="float: right;">C-230</span>   |                     | BALTIMORE CITY HEALTH DEPARTMENT<br><b>72 00893</b> <b>CERTIFICATE OF DEATH</b>   |  | REG. NO. <b>72 00893</b>   |   |
|--|---------------------|---|--|--|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Alexander Cyketa</b>   |                     |   | 2. DATE AND HOUR OF DEATH<br><b>1-23-72</b> <b>11:30AM.</b>  |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>S. BALTO. Hosp.</b>  |                     |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>2505</b> |  |   |
|  |                     |   | C. CITY OR TOWN<br><b>BALTO.</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
|  |                     |   | E. STREET AND NUMBER<br><b>4403 PRUDENCE ST. 21225</b>   |  |   |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>5-10-97</b>   | 9. AGE (In years last birthday) <b>74</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>CRANE OPERATOR</b>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>AUSTRIA</b>                    |   |
| 13. FATHER'S NAME<br><b>JOHN</b>   |                     |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                     |   | 16. SOCIAL SECURITY NO.<br><b>215-07-7944-9</b>  |  | 17. INFORMANT<br><b>SON</b>   |
|  |                     |   |  |  | ADDRESS<br><b>?</b>   |
| 18. <b>410.9 I</b> CAUSE OF DEATH  |                     |   |  |  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |                     |   | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Myocardial infarction</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Four months</b>                            |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                     |   | (B) <b>ASCVD disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:  |  | <b>2 years</b>  |
|  |                     |   | (C)  |  |   |
| <b>II</b>  |                     |   |  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                     |   |  |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)    |   |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>19 48</b> to <b>Jan. 23</b> 19 <b>72</b><br>that (I) (we) last saw the deceased alive on <b>11/11</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |   |  |  |   |
| 23A. SIGNATURE<br><b>J.P. Gehlert</b>  |                     |   |  | 23B. DATE SIGNED<br><b>1/24/72</b>   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. S.R. Gehlert</b>  |                     |   |  | 23D. ADDRESS<br><b>4700 Pennington Ave. Balto. Md. 21226</b>                   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                     | 24B. DATE<br><b>1-26-72</b>   |  | 24C. NAME of CEMETERY or CREMATORY<br><b>HOLY CROSS</b>                        |   |
|  |                     |   |  | 24D. LOCATION (City, town, or county) (State)<br><b>RITCHEY Hwy BALTO. MD.</b> |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1972</b>  |                     | 25B. NAME OF REGISTRAR<br><b>Valerie</b>  |  | 25C. FUNERAL DIRECTOR<br><b>BABAN</b>  |   |
|  |                     |   |  | ADDRESS<br><b>4200 PENNINGTON AVE. 21226</b>                                   |   |

35 00000

35 00000



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                     |   |                                    | REG. NO. <b>72-00894</b>   |
|--|---------------------|---|------------------------------------|--|
| V-520 <b>72 00894</b>  |                     |   |                                    | CERTIFICATE OF DEATH   |
| BIRTH NO.  |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>LELA A. YOUNG</b>   |                                    |  |
| 2. DATE AND HOUR OF DEATH<br><b>1/24/72</b>  |                     | 1:00 P.M.   |                                    |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>md.</b> B. COUNTY <b>2710</b>                          |                                    |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>00</b>  |                     | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>701 E. 43rd ST.</b>  |                                    | C. CITY OR TOWN<br><b>BALTO.</b>   |
| D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                     | E. STREET AND NUMBER<br><b>701 E. 43rd ST.</b>  |                                    |  |
| 5. SEX<br><b>F.</b>  | 6. RACE<br><b>N</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>12/8/01</b> | 9. AGE (In years last birthday)<br><b>70</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>DOMESTIC</b>   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>PRIVATE HOME</b>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>MO.</b>                                    |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                     | 13. FATHER'S NAME<br><b>Geo. Matthew</b>  |                                    |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Martha Jackson</b>  |                     | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                                       |                                    |  |
| 16. SOCIAL SECURITY NO.<br><b>718-18-1373</b>  |                     | 17. INFORMANT<br><b>Earl Young Jr.</b>  |                                    |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>154.1 I</b>  |                     | CAUSE OF DEATH<br><b>Progressive metastatic Carcinoma</b>   |                                    |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 year</b>   |                                    |  |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Carcinoma of the Rectum</b>  |                     | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>1 yr 4 months</b>   |                                    |  |
| (C).....   |                     |   |                                    |  |
| <b>II</b>  |                     |   |                                    |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                     |   |                                    |  |
| 19A. DATE OF OPERATION<br><b>08-20-1970</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Carcinoma of Rectum</b>  |                                    | 20A. AUTOPSY? (Yes or No)<br><b>No</b>   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                     |   |                                    |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><b>No</b>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>None</b>   |                                    | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br><b>None</b> |
| 21D. TIME OF INJURY (APPROX.)<br><b>—</b>  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                    | 21F. HOW DID INJURY OCCUR?<br><b>—</b>   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Oct. 15</b> 19 <b>70</b> to <b>Present</b> 19 <b>71</b> , that (I) (we) last saw the deceased alive on <b>Dec. 16</b> 19 <b>71</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |   |                                    |  |
| 23A. SIGNATURE<br><b>Jaeh Lee</b>  |                     |   |                                    | 23B. DATE SIGNED<br><b>1/25/72</b>   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>JAE M. LEE</b>  |                     |   |                                    | 23D. ADDRESS<br><b>Johns Hopkins Hosp. Tumor Clinic</b>                                    |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burn</b>  |                     | 24B. DATE<br><b>1/28/72</b>   |                                    | 24C. NAME OF CEMETERY OR CREMATORY<br><b>BALTO. NATIONAL</b>                               |
| 24D. LOCATION (City, town, or county) (State)<br><b>BALTO. MD.</b>   |                     | 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1972</b>   |                                    |  |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Lee</b>   |                     | 25C. FUNERAL DIRECTOR<br><b>Christian Funeral Home</b>  |                                    |  |
| ADDRESS<br><b>1701 M. Call</b>   |                     |   |                                    |  |

35404-27

35404-27

2000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                          |  |   |
|--|--------------------------|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT   |                          | REG. NO. <b>72 00895</b>   |   |
| BIRTH NO. <b>H-260</b>   |                          | 72 00895 CERTIFICATE OF DEATH  |   |
| 1. NAME OF DECEASED<br><b>HOWSER, GEORGE GORDON</b>  |                          | 2. DATE AND HOUR OF DEATH<br><b>JANUARY 25, 1972 6:00A</b>   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>ST AGNES HOSPITAL</b><br><b>40</b>   |                          | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>1903</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>218 SOUTH GILMORE STREET 21223</b> |   |
| 5. SEX <b>MALE</b>   | 6. RACE <b>CAUCASIAN</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  | 8. DATE OF BIRTH <b>04-18-09</b><br>9. AGE (In years last birthday) <b>62</b><br>10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Mechanic</b>   |                          | 10B. KIND OF BUSINESS OR INDUSTRY  |   |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>   |                          | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |   |
| 13. FATHER'S NAME<br><b>GEORGE HOWSER DEC 'D</b>   |                          | 14. MOTHER'S MAIDEN NAME<br><b>(WHALEN) MARY DEC 'D</b>  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) If yes, give war or dates of service<br><b>YES WW-2</b>  |                          | 16. SOCIAL SECURITY NO.<br><b>213-01-4814</b>  |   |
| 17. INFORMANT<br><b>RECORD 'S BALTIMORE MD 21229</b>   |                          | <b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>   |   |
| 18. <b>569.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE <b>Cardiac Arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>Renal failure, pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>CR bleeding</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                          |                          |  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                          |  |   |
| 19A. DATE OF OPERATION<br><b>2</b>   |                          | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   |
| 20A. AUTOPSY? (Yes or No)<br><b>yes</b>  |                          | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |                          | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |                          |  |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)   |                          | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   |
| 21F. HOW DID INJURY OCCUR?   |                          |  |   |
| 22. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>JANUARY 7, 1972</b> to <b>JANUARY 25, 1972</b> that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <b>JANUARY 25, 1972</b> and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (We) (did) <input checked="" type="checkbox"/> view the body after death. |                          |  |   |
| 23A. SIGNATURE<br><b>[Signature]</b>   |                          | 23B. DATE SIGNED   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>BILL KASS MD</b>  |                          | 23D. ADDRESS<br><b>BALTIMORE MD 21229</b><br><b>ST AGNES HOSPITAL WILKENS &amp; CATON AVE</b>  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                          | 24B. DATE<br><b>1-28-72</b>  |   |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Holy Cross Cemt.</b>  |                          | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>   |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1972</b>  |                          | 25B. NAME OF REGISTRAR<br><b>[Signature]</b>   |   |
| 25C. FUNERAL DIRECTOR<br><b>[Signature]</b>  |                          | ADDRESS<br><b>100 E. Fort Ave. 21230</b>   |   |

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

000000

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                     |   |  |  |  |   |  |   |  |
|---|---------------------|---|--|--|--|---|--|---|--|
| E-152   |                     | 72 00896  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | CERTIFICATE OF DEATH  |  | REG. NO. 72 00896   |  |
| BIRTH NO.   |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>EVANS LIZETTA T.</b>  |  |  |  | 2. DATE AND HOUR OF DEATH<br><b>1-25-72 3 P.M.</b>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                     |   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)             |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>SO. BALTO. GEN. HOSPITAL,</b><br><b>43</b>   |                     |   |  |  |  | A. STATE<br><b>Maryland</b>   |  |   |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                     |   |  |  |  | C. CITY OR TOWN<br><b>Baltimore</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|   |                     |   |  |  |  | E. STREET AND NUMBER<br><b>1013 Herdon Court</b>  |  |   |  |
| 5. SEX<br><b>F</b>  | 6. RACE<br><b>W</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>9-7-1901</b>  |  | 9. AGE (In years last birthday)<br><b>70yr.</b>   |  | 10. Under 1 Yr. Months Days<br>11. Under 24 Hrs. Hours Min.                                   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                     |   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                      |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Albert Lamm</b>   |                     |   |  |  |  | 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                     |   |  | 16. SOCIAL SECURITY NO.<br><b>218-09-9129 D</b>  |  | 17. INFORMANT<br><b>John P. Evans Box 149 Pt. Pleasant</b>  |  | ADDRESS<br><b>Glen Md</b>   |  |
| 18. <b>480X4-207.9</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Cardiogenic Shock &amp; renal Shut down</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Severe Metabolic Acidosis</b><br><b>Hypertensive Myocardial Infarction</b><br><b>Viral Pneumonia, poss</b><br><b>Viral Pneumonia, poss. Leukemia</b> |                     |   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| MEDICAL CERTIFICATION   |                     |   |  |  |  |   |  |   |  |
| 19A. DATE OF OPERATION<br><b>2</b>  |                     |   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                     |   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                          |  |   |  |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)   |                     |   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1-21-1972</b> to <b>1-25-1972</b> that (I) (we) last saw the deceased alive on <b>1-25-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                     |   |  |  |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Muri Mathur</b><br>DEGREE  |                     |   |  |  |  | 23B. DATE SIGNED<br><b>1-25-72</b>  |  | 23C. PHYSICIAN'S NAME (Type)<br><b>MURIEL MATHUR</b><br><b>Intern MD</b><br>DEGREE            |  |
| 23D. ADDRESS<br><b>81 Balto. Gen. Hosp.</b>   |                     |   |  |  |  |   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     | 24B. DATE<br><b>1/28/72</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Western Cemetery</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Md.</b>                             |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1972</b>   |                     |   |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Kelly</b>   |  | 25C. FUNERAL DIRECTOR<br><b>000000</b><br>ADDRESS<br><b>000000 Federal Homes 130 E. Fort Ave.</b> |  |   |  |

2000 25

2000 25

191

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |  |
|---|--|---|--|
| <div style="display: flex; justify-content: space-between;"> <span>L-500</span> <span>72 00897</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>  |  | REG. NO. <span style="font-size: 1.5em;">72 00897</span>  |  |
| BIRTH NO. <span style="font-size: 1.5em;">L-500</span>  |  | 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">LEON, DAISY M.</span>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br><span style="font-size: 1.5em;">42 SINAI HOSPITAL BALTIMORE</span>   |  | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">JAN. 24, 1972</span> <span style="font-size: 1.2em;">1:58 P.M.</span>  |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <span style="font-size: 1.2em;">MD</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE</span>  |  | C. CITY OR TOWN <span style="font-size: 1.2em;">Randallstown</span> D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>  |  |
| E. STREET AND NUMBER<br><span style="font-size: 1.2em;">9802 KERRIGAN CT. 21133</span>  |  |   |  |
| 5. SEX <span style="font-size: 1.2em;">F</span>   | 6. RACE <span style="font-size: 1.2em;">White</span> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <span style="font-size: 1.2em;">June 8, 1915</span>   |
| 9. AGE (In years last birthday) <span style="font-size: 1.2em;">56</span>   |  | If Under 1 Yr. Months: Days: Hours: Min.  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">Housewife</span> |
| 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">Baltimore, Maryland</span>   |  | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><span style="font-size: 1.2em;">Washington Jackson King</span>   |  | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">Daisy Bryan (Guthrie)</span>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.2em;">No None</span>  |  | 16. SOCIAL SECURITY NO.<br><span style="font-size: 1.2em;">219-10-1905</span>   |  |
| 17. INFORMANT <span style="font-size: 1.2em;">Randallstown, Md. 21133</span> ADDRESS<br><span style="font-size: 1.2em;">Mr. Julius Leon 9802 Kerrigan Court</span>  |  |   |  |
| 18. <span style="font-size: 1.5em;">486 X 14201X</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | CAUSE OF DEATH<br><span style="font-size: 1.2em;">GRAM NEGATIVE SEPTICEMIA</span><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.2em;">PNEUMONIA</span><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><span style="font-size: 1.2em;">Hodgkin's disease - ASCVD</span>  |  |   |  |
| 19A. DATE OF OPERATION <span style="font-size: 1.2em;">2</span>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">YES</span>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  |
| 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (if) (this hospital) attended the deceased from <span style="font-size: 1.2em;">JAN. 14</span> 19 <span style="font-size: 1.2em;">72</span> to <span style="font-size: 1.2em;">JAN. 24</span> 19 <span style="font-size: 1.2em;">72</span> that (if) (we) last saw the deceased alive on <span style="font-size: 1.2em;">JAN. 24</span> 19 <span style="font-size: 1.2em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (if) (We) (did) (did not) view the body after death. |  |   |  |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">Armando C. Dinamico, M.D.</span>  |  | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">Jan. 24, 1972</span>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">ARMANDO C. DINAMICO, MD.</span>   |  | 23D. ADDRESS<br><span style="font-size: 1.2em;">Sinai Hosp. Baltimore</span>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>   |  | 24B. DATE<br><span style="font-size: 1.2em;">1/27/1972</span>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><span style="font-size: 1.2em;">Woodlawn Cemetery</span>  |  | 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">Woodlawn, Md. Balto. Co. Md.</span>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">JAN 27 1972</span>   |  | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">Robert E. Jones, M.D.</span>  |  |
| 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">8728 Liberty Rd. 21133</span>  |  | 25D. ADDRESS<br><span style="font-size: 1.2em;">Loriby Bryan Funeral Directors, Pa.</span>  |  |

10-20-00-55

10-20-00-55

10-20-00-55

10-20-00-55

10-20-00-55

10-20-00-55

10-20-00-55

10-20-00-55

10-20-00-55

10-20-00-55

10-20-00-55

10-20-00-55

10-20-00-55

10-20-00-55



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00898

BIRTH NO.

REG. NO.

|  |                         |   |  |   |  |   |  |  |
|--|-------------------------|---|--|---|--|---|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Charles Green</b>   |                         |   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>1 25 72 5:55 A. M.</b>  |  |   |  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>44 Union Memorial Hospital</b>  |                         |   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>1 25 72 5:55 A. M.</b>   |  |   |  |  |
| 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE<br><b>Maryland</b>   |                         |   |  | B. COUNTY<br><b>2744</b>  |  |   |  |  |
| 6. SEX<br><b>Male</b>  | 7. RACE<br><b>White</b> | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | C. CITY OR TOWN<br><b>Baltimore</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |
| 9. DATE OF BIRTH<br><b>1/4/1915</b>  |                         | 10. AGE (in years lost birthday)<br><b>57</b>   |  | E. STREET AND NUMBER<br><b>3033 Hamilton Avenue</b>   |  |   |  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  | 13. FATHER'S NAME<br><b>Frank Green</b>   |  |   |  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Driver</b>   |                         | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Crown Oil Co.</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Amelia ?</b>   |  |   |  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                         | 17. SOCIAL SECURITY NO.<br><b>215-03-7176</b>   |  | 18. INFORMANT<br><b>Mrs. Erma V. Green</b>  |  | ADDRESS<br><b>Same</b>  |  |  |
| 19. <b>412.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                         |   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br><b>Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| 20A. DATE OF OPERATION<br><b>2</b>   |                         | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  | 21. AUTOPSY? (Yes or No)<br><b>Yes</b>  |  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                         | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?  |  |   |  |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                         | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 22F. HOW DID INJURY OCCUR?  |  |   |  |  |
| 23.<br>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br><br>ACTUAL SIGNATURE <b>Werner U. Spitz</b> Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <b>1-25-72</b> |                         |   |  |   |  |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>1/29/72</b>   |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Parkwood Cemetery</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Maryland</b>                    |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1972</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Leonard J. Ruck Inc. 5305 Harford Rd</b>  |  |   |  |  |

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

12-10-50

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                   |   |                                    |   |                            |  |                             |
|---|-------------------|---|------------------------------------|---|----------------------------|--|-----------------------------|
| L-100   |                   | 72 00899  |                                    | BALTIMORE CITY HEALTH DEPARTMENT  |                            | REG. NO. 72 00899  |                             |
| BIRTH NO.   |                   |   |                                    | 1   |                            |  |                             |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Lippy, Ellen O.</u>   |                   |   |                                    | 2. DATE AND HOUR OF DEATH<br><u>1-25-1972</u> <u>1 7 43</u> M.  |                            |  |                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                   |   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)   |                            |  |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Montebello State Hospital</u><br><u>2201 Argonne Drive</u><br><u>Balto Md 21218</u>  |                   |   |                                    | A. STATE <u>Maryland</u><br>B. COUNTY <u>2734</u>   |                            |  |                             |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                   |   |                                    | C. CITY OR TOWN <u>Baltimore</u><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |                            |  |                             |
| E. STREET AND NUMBER <u>4108 Kinsway</u><br><u>21206</u>  |                   |   |                                    |   |                            |  |                             |
| 5. SEX <u>F</u>   | 6. RACE <u>W.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12/30/1893</u> | 9. AGE in years (last birthday) <u>78</u>   | If Under 1 Yr. Months Days |  | If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                   |   |                                    | 10B. KIND OF BUSINESS OR INDUSTRY   |                            | 11. BIRTHPLACE (State or foreign country)  |                             |
| <u>Sales- Hochschild Kohn</u>   |                   |   |                                    | <u>Baltimore Md</u>   |                            | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>  |                             |
| 13. FATHER'S NAME<br><u>Frank R. Gatch</u>  |                   |   |                                    | 14. MOTHER'S MAIDEN NAME<br><u>Olivia Evans</u>   |                            |  |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>no</u>   |                   |   |                                    | 16. SOCIAL SECURITY NO.<br><u>220-22-8638</u>   |                            | 17. INFORMANT<br><u>Earl F. Lippy same</u>   |                             |
| 18. <u>436.9 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                   |   |                                    | CAUSE OF DEATH<br><u>Heart failure and Respiratory distress</u><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><u>C. V. A. &amp; Hemiplegia 11-18-71</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                            |  |                             |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                   |   |                                    |   |                            |  |                             |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                   |   |                                    |   |                            |  |                             |
| 19A. DATE OF OPERATION  |                   |   |                                    | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                            | 20A. AUTOPSY? (Yes or No) <u>None</u>  |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <u>NO</u>   |                   |   |                                    | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) <u>NO</u>   |                            | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) <u>NO</u> |                             |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour) <u>NO</u>   |                   |   |                                    | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                            | 21F. HOW DID INJURY OCCUR? <u>NO</u>   |                             |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____ that (I) (we) last saw the deceased alive on <u>January 15 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                           |                   |   |                                    |   |                            |  |                             |
| 23A. SIGNATURE <u>Wing Kwei Lin M.D.</u>  |                   |   |                                    | 23B. DATE SIGNED <u>January 25-1972</u>   |                            | 23C. PHYSICIAN'S NAME (Type) <u>WING KWEI LIN M.D.</u>                             |                             |
| 23D. ADDRESS <u>MONTABELLO STATE HOSPITAL BALTO</u>   |                   |   |                                    |   |                            |  |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |                   | 24B. DATE   |                                    | 24C. NAME OF CEMETERY or CREMATORY  |                            | 24D. LOCATION (City, town, or county) (State)                                      |                             |
| <u>Burial</u>   |                   | <u>1/27/72</u>  |                                    | <u>Parkwood</u>   |                            | <u>Balto. Md.</u>  |                             |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 27 1972</u>  |                   | 25B. NAME OF REGISTRAR <u>Robert E. Taylor M.D.</u>   |                                    | 25C. FUNERAL DIRECTOR <u>Leonard J. Ruck Inc. Balto. Md.</u>  |                            |  |                             |

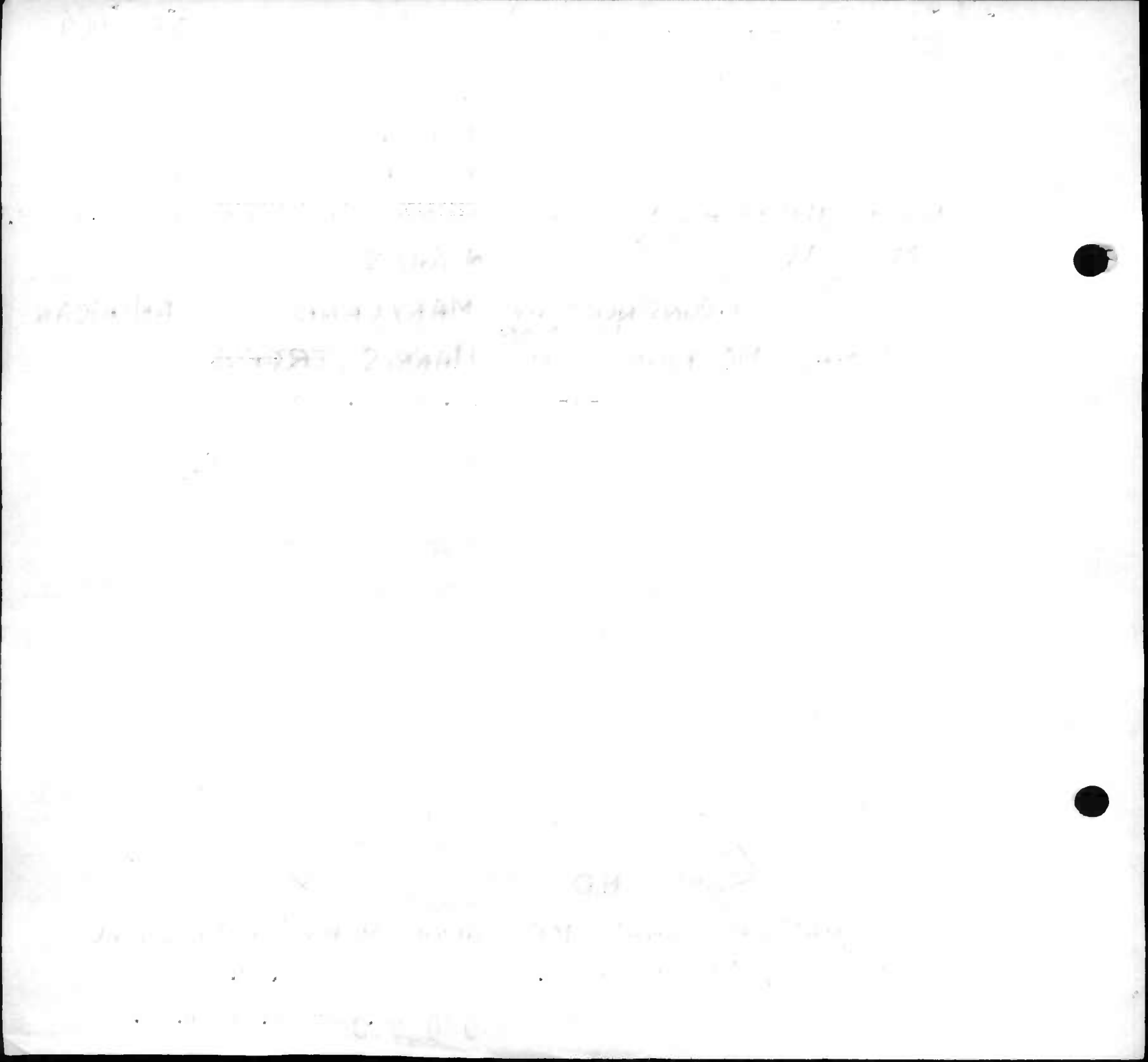
00000 ST

00000 ST

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |  |  |  | REG. NO. <span style="float: right;">72 00900</span>  |  |
|---|--|--|--|---|--|
| BIRTH NO. <span style="float: right;">72 00900</span>   |  | CERTIFICATE OF DEATH   |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MC DONOUGH, JAMES W.</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>1/25/72 10:40 P.M.</b>   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><b>44 UNION MEMORIAL HOSPITAL</b>   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>2759</b>             |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>44 UNION MEMORIAL HOSPITAL</b>   |  | C. CITY OR TOWN<br><b>BALTIMORE</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 5. SEX <b>M</b>   |  | 6. RACE <b>W</b>   |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><b>1/6/31</b>   |  | 9. AGE (In years last birthday)<br><b>41</b>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Supervisor Baiger Co. CONSTRUCTION</b>                     |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA AMERICAN</b>  |  |   |  |
| 13. FATHER'S NAME<br><b>THOMAS MC DONOUGH</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>HARRIS, TREVA</b>   |  |   |  |
| 15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) <b>yes</b><br>If yes, give war or dates of service: <b>Korea</b>  |  | 16. SOCIAL SECURITY NO.<br><b>216-28-4937</b>  |  | 17. INFORMANT<br><b>Mrs. Ma ry C. McDonough same</b>  |  |
| 18. <b>162.1 I</b>  |  | CAUSE OF DEATH   |  |   |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.                   |  | (A) IMMEDIATE CAUSE<br><b>Bronchogenic CA.</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |  |   |  |
| APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |   |  |
| II  |  |  |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, home, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (APPROX.)<br>1 (Month) 1 (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1/25</b> 19 <b>72</b> to <b>1/25</b> 19 <b>72</b> that (I) (we) lost saw the deceased alive on <b>1/25</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |
| 23A. SIGNATURE<br><b>[Signature]</b>  |  |  |  | 23B. DATE SIGNED  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>GHASSAN NAHAS M.D.</b>   |  |  |  | 23D. ADDRESS<br><b>UNION MEMORIAL HOSPITAL</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>1/29/72</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Moreland Mem.</b>  |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>B alto. Md.</b>   |  |  |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1972</b>   |  | 25B. NAME OF REGISTRAR<br><b>[Signature]</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Leonard J. Ruck Inc. Ba lto. Md.</b>  |  |



H-620

72 00901 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 72 00901

BIRTH NO.

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Henry Harris</b>  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month <b>1</b> Day <b>21</b> Year <b>72</b> Hour <b>M.</b> |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>520 S. Ann Street</b>   |  | 3. DATE PRONOUNCED DEAD<br>Month <b>1</b> Day <b>21</b> Year <b>72</b> Hour <b>6:00 a.</b> M.  |  |
| 6. SEX<br><b>male</b>  |  | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>               |  |
| 7. RACE<br><b>White</b>  |  | C. CITY OR TOWN<br><b>Balto.</b>   |  |
| 9. DATE OF BIRTH<br><b>8/24/1915</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>  |  |
| 10. AGE (In years last birthday)<br><b>56</b>  |  | E. STREET AND NUMBER<br><b>520 S. Ann Street</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Va.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Chef</b>   |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>Restaurant</b>   |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 17. SOCIAL SECURITY NO.<br><b>333-22-5067</b>  |  |
| 18. INFORMANT<br><b>Mr. Millard F. Parsons</b>   |  | ADDRESS<br><b>Box 396</b>  |  |
| 19. <b>485X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Acute bronchopneumonia</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) DUE TO, OR AS A CONSEQUENCE OF:<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20A. DATE OF OPERATION<br><b>2</b>   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour) (Min.)  |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 22F. HOW DID INJURY OCCUR?   |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: <b>Natural causes</b> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE: <b>Peter Lipkovic, M.D.</b><br>EXAMINER'S NAME (Type)<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED<br><b>1/21/72</b> |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>Jan. 25, 1972</b>  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Oak Lawn Cem.</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1972</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>G. Truman Schwab</b>   |  | ADDRESS<br><b>3512 Frederick Balto. Md. 21229</b>  |  |

10000 ST

10000 ST

10000 ST

10000 ST

10000 ST

10000 ST



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                     |   |  |
|--|---------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT   |                     | REG. NO. <b>72 00902</b>  |  |
| BIRTH NO. <b>P-412</b>   |                     | 72 00902  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARY ELIZABETH PHILLIPS</b>  |                     | 2. DATE AND HOUR OF DEATH<br><b>JAN 22, 1972 18:05 P.M.</b>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                     | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MARYLAND</b> CITY <b>909</b>                           |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>JOHNS HOPKINS HOSPITAL</b>  |                     | C. CITY OR TOWN<br><b>BALTIMORE</b>   |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>BALTIMORE, MD 21213</b>   |                     | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
|  |                     | E. STREET AND NUMBER<br><b>1411 E. FEDERAL STREET</b>   |  |
| 5. SEX<br><b>F</b>   | 6. RACE<br><b>N</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>8/7/25</b>                              |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>  |                     | 9. AGE (In years last birthday)<br><b>46</b>  | 11. BIRTHPLACE (State or foreign country)<br><b>Balto. Md.</b> |
| 10B. KIND OF BUSINESS OR INDUSTRY  |                     | 12. CITIZEN OF WHAT COUNTRY?  |  |
| 13. FATHER'S NAME<br><b>MANSON COX</b>   |                     | 14. MOTHER'S MAIDEN NAME<br><b>FANNIE DAVIS</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                     | 16. SOCIAL SECURITY NO.   |  |
|  |                     | 17. INFORMANT<br><b>General Carter 1744 N. Bond St</b>  |  |
| 18. <b>573.91</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>METABOLIC ACIDOSIS &amp; RENAL FAILURE</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>HEPATIC FAILURE</b> |                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>16 days</b><br><b>YEARS.</b>   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                     |   |  |
| 19A. DATE OF OPERATION<br><b>1-17-72</b>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>GI HEMORRAGE</b>   |  |
| 20A. AUTOPSY? (Yes or No)<br><b>YES</b>  |                     | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>NO</b>   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><b>NO</b>   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)<br><b>NONE</b>  |  |
| 21C. WHERE DID INJURY OCCUR?<br><b>NONE</b>  |                     | (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.)<br><b>NONE</b>   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  |
|  |                     | 21F. HOW DID INJURY OCCUR?<br><b>NONE</b>   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>JAN 01, 1972</b> to <b>JAN 22, 1972</b> that (I) (we) last saw the deceased alive on <b>JAN 22, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                     |   |  |
| 23A. SIGNATURE<br><b>Marshall M. Urist M.D.</b>  |                     | 23B. DATE SIGNED<br><b>JAN 22, 1972</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>MARSHALL M. URIST M.D.</b>  |                     | 23D. ADDRESS<br><b>THE JOHNS HOPKINS HOSPITAL</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                     | 24B. DATE<br><b>1/27/72</b>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Auburn</b>  |                     | 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1972</b>  |                     | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |  |
|  |                     | 25C. FUNERAL DIRECTOR<br><b>Joseph J. Roberts, Jr. 1304 N. Central St</b>   |  |

800000

300000

1000000

21722

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

1000000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| R-200 72 00903   |                      | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |                                 | REG. NO. 72 00903   |   |
|--|----------------------|--|---------------------------------|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>William H Roach</b>  |                      | 2. DATE AND HOUR OF DEATH<br><b>January 25, 1972 6:10 A.M.</b>   |                                 |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>39 Provident Hospital Complex<br/>2600 Liberty Heights Ave.<br/>Baltimore, Maryland 21215</b>  |                      | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>1547</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>2216 KOKO Lane</b> |                                 |   |   |
| 5. SEX <b>Male</b>   | 6. RACE <b>Negro</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>4/17/84</b> | 9. AGE (In years last birthday) <b>87</b>   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Unemployed</b>   |                      | 10B. KIND OF BUSINESS OR INDUSTRY  |                                 | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |                      | 13. FATHER'S NAME<br><b>Wm. H. Roach</b>   |                                 | 14. MOTHER'S MAIDEN NAME<br><b>FANNIE Fisher.</b>   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                      | 16. SOCIAL SECURITY NO.<br><b>020-30-3919</b>  |                                 | 17. INFORMANT<br><b>Mr. Calvin Roach-Son</b><br>ADDRESS <b>Same</b>   |   |
| 18. <b>412.4 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Respiratory Arrest</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Cardiovascular Disease</b> |                      | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Respiratory Arrest</b>   |                                 | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Cardiovascular Disease</b>  |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                      |  |                                 |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                 | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                      | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                                 |   |   |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                      | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                                 |   |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                 | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>12:00pm Jan. 18, 1972</b> to <b>6:10 AM Jan. 25, 1972</b> that (I) (we) last saw the deceased alive on <b>January 24, 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                      |  |                                 |   |   |
| 23A. SIGNATURE<br><b>Lewis B. Boone, M.D.</b>  |                      | 23B. DATE SIGNED<br><b>January 25, 1972</b>  |                                 | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Lewis B. Boone M.D.</b>   |                      | 23D. ADDRESS<br><b>2600 Liberty Heights Ave.</b>   |                                 |   |   |
| 24A. BURIAL CREMATION REMOVAL (Specify)<br><b>Burial</b>   |                      | 24B. DATE<br><b>1/28/72</b>  |                                 | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Mt. Calvary</b>  |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>D.C. County Md.</b>  |                      | 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1972</b>  |                                 |   |   |
| 25B. NAME OF REGISTRAR<br><b>John E. ...</b>   |                      | 25C. FUNERAL DIRECTOR<br><b>Joseph ...</b>   |                                 | ADDRESS<br><b>1304 N. ...</b>   |   |

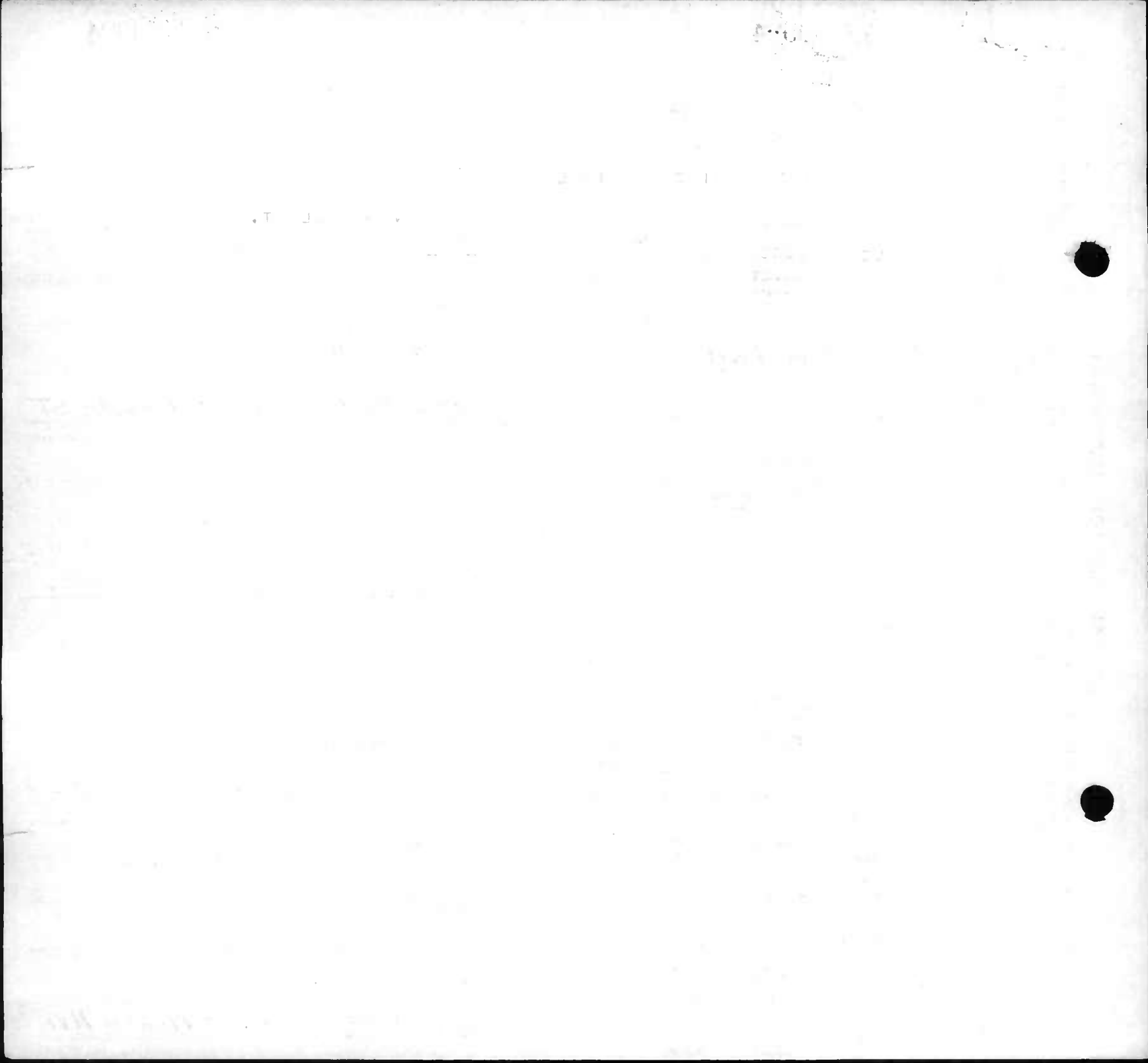
ENCLOSURE 22

2000. 5.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                         |   |                                     |   |  |
|---|-------------------------|---|-------------------------------------|---|--|
| K3592 00904   |                         | BALTIMORE CITY HEALTH DEPARTMENT  |                                     | REG. NO. 72-00904   |  |
| BIRTH NO.   |                         | CERTIFICATE OF DEATH  |                                     |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Estelle Keaton</i>  |                         | 2. DATE AND HOUR OF DEATH<br><i>1/26/72</i> <i>1:20 P.M.</i>  |                                     |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>33 THE JOHNS HOPKINS HOSPITAL</i>   |                         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>MARYLAND</i> B. COUNTY <i>808</i>  |                                     |   |  |
|   |                         | C. CITY OR TOWN<br><i>BALTIMORE</i>   |                                     | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|   |                         | E. STREET AND NUMBER<br><i>1019 N. CHAPEL ST.</i>   |                                     |   |  |
| 5. SEX<br><i>FEMALE</i>   | 6. RACE<br><i>NEGRO</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><i>10-10-04</i> | 9. AGE (In years last birthday) <i>67</i>   | 10. Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                         | 10B. KIND OF BUSINESS OR INDUSTRY   |                                     | 11. BIRTHPLACE (State or foreign country)<br><i>N.C.</i>                                      |  |
| 12. CITIZEN OF WHAT COUNTRY?  |                         | 13. FATHER'S NAME<br><i>Thomas A. Phifer</i>  |                                     |   |  |
| 14. MOTHER'S MAIDEN NAME<br><i>MARY ALLEN</i>   |                         | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                                     |   |  |
| 16. SOCIAL SECURITY NO.   |                         | 17. INFORMANT<br><i>MARY E BOSTON</i> ADDRESS <i>1907 E EAGER ST</i>  |                                     |   |  |
| 18. <i>421.01</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><i>Pulmonary Embolus</i><br>(B) <i>Renal Steep Group B Section</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>probable ABF</i> |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |   |                                     |   |  |
| 19A. DATE OF OPERATION  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     | 20A. AUTOPSY? (Yes or No)   |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                         | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |                                     |   |  |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                         | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                     |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                     | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (1) (this hospital) attended the deceased from <i>1/16</i> 19 <i>72</i> to <i>1/26</i> 19 <i>72</i> that (1) (we) last saw the deceased alive on <i>1/16</i> 19 <i>72</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.   |                         |   |                                     |   |  |
| 23A. SIGNATURE<br><i>J. H. H. H.</i>  |                         | 23B. DATE SIGNED<br><i>1/26/72</i>  |                                     | 23C. PHYSICIAN'S NAME (Type)<br><i>J. H. H. H.</i>  |  |
| 23D. ADDRESS<br><i>John H. H. H.</i>  |                         | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>   |                                     |   |  |
| 24B. DATE<br><i>1-31-72</i>   |                         | 24C. NAME of CEMETERY or CREMATORY<br><i>Mt. Auburn Cem.</i>  |                                     | 24D. LOCATION (City, town, or county) (State)<br><i>Beths Md.</i>                             |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>JAN 27 1972</i>   |                         | 25B. NAME OF REGISTRAR<br><i>E. J. J. J.</i>  |                                     | 25C. FUNERAL DIRECTOR<br><i>W. J. J. J.</i> ADDRESS <i>928 E NORTH AVE</i>                    |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO. 72 00905

|  |                  |  |                             |   |   |
|--|------------------|--|-----------------------------|---|---|
| T 656<br>BIRTH NO. 72 00905 (Wilbur)   |                  | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |                             | REG. NO. 72 00905   |   |
| 1. NAME OF DECEASED<br>(Type or Print) TURNER, WILBERT J   |                  | 2. DATE AND HOUR OF DEATH<br>1/25/72 6:50 A.M.   |                             |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE MARYLAND B. COUNTY 843   |                             |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>33 Johns Hopkins Hosp  |                  | C. CITY OR TOWN<br>BALTIMORE   |                             | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
|  |                  | E. STREET AND NUMBER<br>2207 BERYL AVE.  |                             |   |   |
| 5. SEX<br>MALE   | 6. RACE<br>NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                     | 8. DATE OF BIRTH<br>6-28-23 | 9. AGE (In years last birthday) 48  | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Laborer   |                  | 10B. KIND OF BUSINESS OR INDUSTRY  |                             | 11. BIRTHPLACE (State or foreign country)<br>VA.  |   |
| 13. FATHER'S NAME<br>THOMAS TURNER   |                  | 14. MOTHER'S MAIDEN NAME<br>ROSA SINGLETON   |                             |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>Yes WW II  |                  | 16. SOCIAL SECURITY NO.<br>214-18-1427   |                             | 17. INFORMANT<br>Idell Turner 1706 Lamont Ave   |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>E9881X<br>Cardio-Resp Arrest<br>MASSIVE BRAIN DAMAGE   |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Cardio-Resp Arrest<br>(B) MASSIVE BRAIN DAMAGE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |                             | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 min<br>75 days                             |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                  |  |                             |   |   |
| 19A. DATE OF OPERATION<br>2/11/71  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Subdural   |                             | 20A. AUTOPSY (Yes or No)<br>Yes   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>Street 1570 Bk. Asquith St   |                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>NO                    |   |
| 21D. TIME OF INJURY (APPROX.)<br>11-12-71 2:26 P   |                  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>   |                             | 21F. HOW DID INJURY OCCUR?<br>Unknown   |   |
| 22. I certify that (I) (this hospital) attended the deceased from 11/26/1971 to 1/25/1972 that (I) (we) last saw the deceased alive on 1/25/1972 and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |  |                             |   |   |
| 23A. SIGNATURE<br>Gunduz Gucer MD  |                  | 23B. DATE SIGNED<br>1/25/72  |                             | 23C. PHYSICIAN'S NAME (Type)<br>Gunduz Gucer  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>1-29-72   |                             | 24C. NAME of CEMETERY or CREMATORY<br>Mt. Auburn Cem  |   |
| 24D. LOCATION<br>Baltimore Md  |                  | 25A. DATE REC'D BY HEALTH DEPT.<br>JAN 27 1972   |                             | 25B. NAME OF REGISTRAR<br>Wm. M. MARCH  |   |
| 25C. FUNERAL DIRECTOR<br>928 E NORTH AVE   |                  | 25D. ADDRESS   |                             |   |   |

2707 Beryl Ave. at 11-12

7-10-11

ET

11-10-11

11-10-11

11-10-11

11-10-11

11-10-11

11-10-11

11-10-11



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |              |   |                               |   |  |   |  |
|---|--------------|---|-------------------------------|---|--|---|--|
| S-356   |              | 72 00906  |                               | BALTIMORE CITY HEALTH DEPARTMENT  |  | 72 00906  |  |
| BIRTH NO.   |              |   |                               | REG. NO.  |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) MR. REGINALD STONER  |              |   |                               | 2. DATE AND HOUR OF DEATH<br>January 24, 1972 8:20 A.M.   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |              |   |                               | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE MD B. COUNTY 2802   |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>KESWICK HOME FOR INCURABLES OF BALTO. CITY Balto., 21211, MD.  |              |   |                               | C. CITY OR TOWN<br>BALTO  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|   |              |   |                               | E. STREET AND NUMBER<br>3305 Ferndale Ave. 21207  |  |   |  |
| 5. SEX<br>M   | 6. RACE<br>W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br>7-25-1893 | 9. AGE (In years last birthday)<br>78   | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Salesman   |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>????   |                               | 11. BIRTHPLACE (State or foreign country)<br>Westminster, Md.   |  | 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  |
| 13. FATHER'S NAME<br>Samuel C. Stoner   |              |   |                               | 14. MOTHER'S MAIDEN NAME<br>Emma Synder   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO NO   |              | 16. SOCIAL SECURITY NO.<br>212-07-1919  |                               | 17. INFORMANT ADDRESS<br>KESWICK FILES 700 W. 40th St.  |  |   |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last |              |   |                               | (A) IMMEDIATE CAUSE<br>Due to, or as a consequence of:<br>Coronary Thrombosis<br>For C. R. K. K. K.<br>(B) Abdominal - treated Resection Colon<br>Due to, or as a consequence of:<br>(C) Carcinoma of the Rectum - treated<br>Fracture of the left leg with deformity |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 instant<br>7 yrs.<br>10 months<br>9 yrs     |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |              |   |                               |   |  |   |  |
| 19A. DATE OF OPERATION  |              | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                               | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |              | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |              | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                               | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 18 Feb 1971 to 24 Jan 1972 that (I) (we) last saw the deceased alive on 24 Jan 1972 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                       |              |   |                               |   |  |   |  |
| 23A. SIGNATURE<br>Aubrey D. Richardson, M.D.  |              |   |                               | 23B. DATE SIGNED<br>24 Jan 1972   |  | 23C. PHYSICIAN'S NAME (Type)<br>Aubrey D. Richardson, M.D.                                    |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br>Burial   |              | 24B. DATE<br>1/26/72  |                               | 24C. NAME OF CEMETERY OR CREMATORY<br>Westminster Cem.  |  | 24D. LOCATION (City, town, or county) (State)<br>Westminster, Carroll, Md.                    |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>JAN 27 1972  |              | 25B. NAME OF REGISTRAR<br>Robert E. Taylor  |                               | 25C. FUNERAL DIRECTOR<br>Robert E. Taylor Jr. 91 W. 40th St. Westminster, Md.   |  |   |  |

81000 SS

81000 SS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                  |   |  |
|--|------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT   |                  | REG. NO. <b>72 00907</b>  |  |
| <b>72 00907</b>  |                  | <b>CERTIFICATE OF DEATH</b>   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MILDRED B. WILSON</b>  |                  | 2. DATE AND HOUR OF DEATH<br><b>1-19-72 4:45 P.M.</b>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Union Memorial Hosp<br/>Balt, Md.</b>  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>2710</b><br>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>740 E. Cold Spring Lane</b> |  |
| 5. SEX <b>F</b>  | 6. RACE <b>N</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <b>04-06-95</b> 9. AGE (In years last birthday) <b>76</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>  |                  | 10B. KIND OF BUSINESS OR INDUSTRY <b>—</b>  |  |
| 11. BIRTHPLACE (State or foreign country) <b>NORTH CAROLINA</b>  |                  | 12. CITIZEN OF WHAT COUNTRY? <b>USA</b>   |  |
| 13. FATHER'S NAME <b>WILLIAM BRAXTON</b>   |                  | 14. MOTHER'S MAIDEN NAME <b>EMMA</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No</b>   |                  | 16. SOCIAL SECURITY NO. <b>-A 243-07-1399</b>   |  |
| 17. INFORMANT <b>Son McKinley W. Wilson, Jr.</b>   |                  | ADDRESS <b>same as above</b>  |  |
| 18. <b>344.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Uremia</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Undetermined</b> |                  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>Rt. Hemiparesis, complete</b>  |  |
| 19A. DATE OF OPERATION <b>0</b>  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY? (Yes or No) <b>No</b>  |                  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined) <input type="checkbox"/>   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)   |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1-04</b> 19 <b>72</b> to <b>1-19</b> 19 <b>72</b> and that (I) (we) lost saw the deceased alive on <b>1-18</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                                      |                  |   |  |
| 23A. SIGNATURE <b>W. P. Benson, Jr. M.D.</b>   |                  | 23B. DATE SIGNED <b>1-19-72</b>   |  |
| 23C. PHYSICIAN'S NAME (Type) <b>W. BENSON</b>  |                  | 23D. ADDRESS <b>3506 N. Calvert Baltimore, Md.</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>BURIAL</b>   |                  | 24B. DATE <b>1-22-72</b>  |  |
| 24C. NAME OF CEMETERY OR CREMATORY <b>GLENVIEW MEM. PARK</b>   |                  | 24D. LOCATION (City, town, or county) (State) <b>DURHAM - NORTH CAROLINA</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1972</b>   |                  | 25B. NAME OF REGISTRAR <b>John E. Taylor M.D.</b>   |  |
| 25C. FUNERAL DIRECTOR <b>Good &amp; Sons</b>   |                  | ADDRESS <b>2101 FRED'K AVE.</b>   |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |  |  | REG. NO. <b>72 00908</b>  |  |
|--|--|--|--|---|--|
| S-530  |  | 72 00908   |  | CERTIFICATE OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>SMITH JOHN C.</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>1/26/72 2.00 P.M.</b>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><b>34 BOW SECOURS HOSPITAL</b>   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>2001</b>  |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>34 BOW SECOURS HOSPITAL</b>   |  | C. CITY OR TOWN<br><b>BALTIMORE</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 5. SEX <b>MALE</b>   |  | 6. RACE <b>WHITE</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br><b>9-03-95</b>   |  | 9. AGE (In years last birthday) <b>76</b>  |  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>RETIRED FROM ELECTRO-LUX</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>ELECTRO-LUX</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>ENGLAND</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>ENGLISH</b>   |  | 13. FATHER'S NAME<br><b>SIDNEY SMITH</b>   |  | 14. MOTHER'S MAIDEN NAME<br><b>ANETTE BOULTER</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.<br><b>265-09-4233</b>  |  | 17. INFORMANT<br><b>Mrs M Doney 1839 W Fairmount Ave</b>  |  |
| 18. <b>436.914162.1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <b>Respiratory arrest.</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <b>① CVA ② Bronchogenic C.A.</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>③ Pneumonia</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |  |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>-</b>   |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |  |   |  |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>-</b>   |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br><b>-</b>  |  |   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br><b>-</b>   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?<br><b>-</b>  |  |
| 22. I certify that (H) (this hospital) attended the deceased from <b>1/22/72</b> 19 <b>72</b> to <b>1/26</b> 19 <b>72</b> that (H) (we) last saw the deceased alive on <b>1/26</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (H) (We) (did) (did not) view the body after death.         |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Richard A. Rong Songgram M.D.</b>   |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |  | 23B. DATE SIGNED  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ARVORANEE RICHARD A. RONG SONGGRAM M.D.</b>   |  | 23D. ADDRESS   |  |   |  |
| 24A. BURIAL, CREMATION, REMOVAL (Specify)<br><b>cremation</b>  |  | 24B. DATE<br><b>1-27-72</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Louden Park</b>  |  |
| 24D. LOCATION<br><b>Balto. Md</b>  |  | (City, town, or county) (State)  |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1972</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, F.D. 2 0 0 0</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Do? Scholtzme 2101 Frederick Ave</b>  |  |
| ADDRESS  |  |  |  |   |  |

AS 10112

2 6 3 9

1  
L-260

| T-512  |                  | 72 00909  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | MEDICAL EXAMINER'S CERTIFICATE OF DEATH   |  | REG. NO. 72 00909                            |  |
|--|------------------|---|--|---|--|---|--|--|--|
| BIRTH NO.  |                  | 1. NAME OF DECEASED (Mary Locker)<br>(Type or Print) <b>Alberta Thompson</b>  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month Day Year Hour<br>Estimated <input type="checkbox"/> 1 25 72 6:50 A.M. |  |   |  |  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>00 1717 Barclay Street |                  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br>1 25 72 6:50 P.M.   |  | 5. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Maryland B. COUNTY 1205                 |  |   |  |  |  |
| 6. SEX<br>Female   | 7. RACE<br>Negro | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | C. CITY OR TOWN<br>Baltimore  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |  |  |
| 9. DATE OF BIRTH<br>10-6-08  |                  | 10. AGE (in years lost birthday) 63   |  | E. STREET AND NUMBER<br>1717 Barclay Street   |  |   |  |  |  |
| 11. BIRTHPLACE (State or foreign country)<br>Pennsylvania  |                  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  | 13. FATHER'S NAME<br>John   |  |   |  |  |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife                 |                  | 14B. KIND OF BUSINESS OR INDUSTRY   |  | 15. MOTHER'S MAIDEN NAME<br>Mary  |  |   |  |  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>no            |                  | 17. SOCIAL SECURITY NO.<br>218-09-8878  |  | 18. INFORMANT<br>Mrs. Mattie Johnson 1717 Barclay St. 21202   |  |   |  |  |  |
| MEDICAL CERTIFICATION  |                  | 19. CAUSE OF DEATH  |  |   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |  |
|  |                  | DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>(A) IMMEDIATE CAUSE Arteriosclerotic cardiovascular disease</b><br>DUE TO, OR AS A CONSEQUENCE OF:   |  |   |  |   |  |  |  |
|  |                  | ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(B)</b><br>DUE TO, OR AS A CONSEQUENCE OF:   |  |   |  |   |  |  |  |
|  |                  | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>(C)</b>  |  |   |  |   |  |  |  |
| 20A. DATE OF OPERATION<br>0  |                  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |   |  |   |  | 21. AUTOPSY? (Yes or No)<br>No               |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.     |                  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR?  |  |   |  |  |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 22F. HOW DID INJURY OCCUR?  |  |   |  |  |  |
| 23.  |                  | I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br><br>ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>EXAMINER'S NAME (Type) <b>Werner U. Spitz, M.D.</b> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED 1-25-72 |  |   |  |   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |                  | 24B. DATE<br>1-28-1972  |  | 24C. NAME of CEMETERY or CREMATORY<br>Mt. Auburn Cemetery   |  | 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland                          |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>JAN 27 1972   |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor, M.D.  |  | 25C. FUNERAL DIRECTOR 1735 Harford Ave. 21213<br>Marshall W. Jones, Jr.   |  |   |  |  |  |

72 00909

✓

2000000000

2000000000

2000000000

2000000000

2000000000

2000000000

2000000000

2000000000

2000000000

2000000000

2000000000

2000000000

2000000000

2000000000

2000000000

2000000000

2000000000

2000000000

2000000000



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

RGB

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| B530 72 00910   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 72 00910   |  |
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) PEARLIE MAE BOND  |  | 2. DATE AND HOUR OF DEATH<br>Jan. 24, 1972 3 A M.                                     |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Virginia B. COUNTY |  | V 43  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>US Public Health Service Hospital<br>3100 Wyman Parkway   |  | C. CITY OR TOWN<br>Virginia Beach  |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>    |  |
| E. STREET AND NUMBER<br>1203 Carver Ave. Apt. 201   |  | 5. SEX<br>F  |  | 6. RACE<br>Negro  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH<br>3/12/55  |  | 9. AGE (In years last birthday)<br>16   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Student  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br>Va.                                      |  |
| 12. CITIZEN OF WHAT COUNTRY?<br>USA   |  | 13. FATHER'S NAME<br>Armps Bond  |  | 14. MOTHER'S MAIDEN NAME<br>Marie Barnard   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |  | 16. SOCIAL SECURITY NO.<br>228-86-3161   |  | 17. INFORMANT<br>Records- US PHS Hospital, Balto, Md.                                 |  |
| 18. 206.0 I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br>Bilateral pulmonary hemorrhages  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>Sudden   |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>Acute monocytic leukemia  |  | 1 month  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  |  |  |   |  |
| 19A. DATE OF OPERATION<br>2   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br>yes  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                             |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)           |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>            |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from Jan. 17 19 72 to Jan. 24 19 72, that (I) (we) last saw the deceased alive on Jan. 24 19 72 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |
| 23A. SIGNATURE<br>Robert E. Belliveau M.D. (Surgeon)  |  |  |  | 23B. DATE SIGNED<br>1/24/72   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Robert E. Belliveau, Surgeon (R)  |  |  |  | 23D. ADDRESS<br>US PHS Hospital, Balto, Md. 21211                                     |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>transit-burial  |  | 24B. DATE<br>1-29-72   |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Jones Memorial Park                             |  |
| 24D. LOCATION<br>Virginia Beach, Virginia   |  | 24E. LOCATION<br>(City, town, or county) (State)   |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>JAN 27 1972  |  | 25B. NAME OF REGISTRAR<br>Robert E. Belliveau, M.D.  |  | 25C. FUNERAL DIRECTOR<br>1210 Ballentine Blvd.<br>Community Funeral Home Norfolk, Va. |  |

01011 SS

01011 SS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |  |
|--|--|---|--|
| <p><b>8-420 72 00911</b></p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>CERTIFICATE OF DEATH</b></p>  |  | <p>REG. NO. <b>72 00911</b></p>   |  |
| <p>BIRTH NO. <b>8-420</b></p>  |  | <p>1. NAME OF DECEASED (Type or Print) <b>MARY E. Schools</b></p>   |  |
| <p>2. DATE AND HOUR OF DEATH <b>(MD) Jan 26, 1972 7:00 A.M.</b></p>  |  | <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>   |  |
| <p>FULL NAME OF HOSPITAL OR INSTITUTION <b>46 Lutheran Hospital of Md</b></p>  |  | <p>4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)</p> <p>A. STATE <b>Md.</b> B. COUNTY <b>2303</b></p> |  |
| <p>C. CITY OR TOWN <b>Baltimore</b></p>  |  | <p>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>   |  |
| <p>E. STREET AND NUMBER <b>17 W. Baerney St. 21230</b></p>   |  | <p>5. SEX <b>Female</b> 6. RACE <b>White</b></p>  |  |
| <p>7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>   |  | <p>8. DATE OF BIRTH <b>7-22-08</b> 9. AGE (In years last birthday) <b>63</b></p>  |  |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Bottle caper</b></p>   |  | <p>10B. KIND OF BUSINESS OR INDUSTRY <b>Calvert Distillery - Balto Md.</b></p>  |  |
| <p>11. BIRTHPLACE (State or foreign country) <b>Balto Md.</b></p>  |  | <p>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b></p>   |  |
| <p>13. FATHER'S NAME <b>HARVEY E. VALENTINE</b></p>  |  | <p>14. MOTHER'S MAIDEN NAME <b>MARY - S. (?)</b></p>  |  |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>No -</b></p>  |  | <p>16. SOCIAL SECURITY NO. <b>42-05-2571</b></p>  |  |
| <p>17. INFORMANT <b>Harry B. Schools (Husband)</b></p>   |  | <p>ADDRESS <b>243-5, Ellwood Ave. 21224</b></p>   |  |
| <p>18. <b>4 10 19 1</b></p>  |  | <p>CAUSE OF DEATH</p>   |  |
| <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p>  |  | <p>(A) IMMEDIATE CAUSE <b>shock</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p>  |  |
| <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>  |  | <p>(B) <b>Myocardial Infarction</b> <b>12 hours</b></p> <p>DUE TO, OR AS A CONSEQUENCE OF:</p>  |  |
| <p>(C) <b>old C.V.A.</b></p>   |  | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>   |  |
| <p><b>II</b></p>   |  |   |  |
| <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>  |  |   |  |
| <p>19A. DATE OF OPERATION <b>0</b></p>   |  | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>   |  |
| <p>20A. AUTOPSY? (Yes or No) <b>No</b></p>   |  | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>   |  |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>  |  | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>  |  |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>  |  | <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)</p>  |  |
| <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>   |  | <p>21F. HOW DID INJURY OCCUR?</p>   |  |
| <p>22. I certify that (I) (this hospital) attended the deceased from <b>1/25/72</b> to <b>1/26/72</b> that (I) (we) last saw the deceased alive on <b>1/25/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> |  |   |  |
| <p>23A. SIGNATURE <b>D. S. KARBNARI</b></p>  |  | <p>23B. DATE SIGNED <b>1/26/72</b></p>  |  |
| <p>23C. PHYSICIAN'S NAME (Type) <b>D. S. KARBNARI</b></p>  |  | <p>23D. ADDRESS <b>LUTHERAN HOSPITAL BALTO MD</b></p>   |  |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b></p>  |  | <p>24B. DATE <b>Jan 29-72</b></p>   |  |
| <p>24C. NAME OF CEMETERY OR CREMATORY <b>Landon Park Cemetery</b></p>  |  | <p>24D. LOCATION (City, town, or county) (State) <b>Balto Md.</b></p>   |  |
| <p>25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1972</b></p>  |  | <p>25B. NAME OF REGISTRAR <b>Robert E. Taylor MD</b></p>  |  |
| <p>25C. FUNERAL DIRECTOR <b>CURTIS E. EVANS</b></p>  |  | <p>ADDRESS <b>4605, Charles St. Balto 21230</b></p>   |  |

1908 SS

1908 SS

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. 72-00912  |  |
|---|--|--|--|--|--|
| BIRTH NO. 72-00912  |  | 1. NAME OF DECEASED (Type or Print) Anthony Michael Valenti  |  |  |  |
| 2. DATE AND HOUR OF DEATH January 25, 1972  |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) 00 326 S. Clinton Street  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) Maryland 2610    |  |  |  |
| 5. SEX Male   |  | 6. RACE Caucasian  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH 10/8/15  |  | 9. AGE (In years last birthday) 56   |  | 10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Hours Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railor  |  | 10B. KIND OF BUSINESS OR INDUSTRY Madel  |  | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland  |  |
| 13. FATHER'S NAME Sebastian Valenti   |  | 14. MOTHER'S MAIDEN NAME Josephine Mason   |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (If yes, no or unknown) no   |  | 16. SOCIAL SECURITY NO. 217-09-7463  |  | 17. INFORMANT Mrs. Eleanor Valenti - same ADDRESS  |  |
| 18. CAUSE OF DEATH  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: Metastatic Carcinoma Liver                         |  |  |  |
| ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  | (B) Carcinoma Sigmoid Colon 1 yr.  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  | (C)  |  |  |  |
| 19A. DATE OF OPERATION 3/71   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Sigmoid                                     |  | 20A. AUTOPSY? (Yes or No) No   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notably medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from March 1971 to Jan 10 1972 that (I) (we) last saw the deceased alive on 1/10 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |  |  |
| 23A. SIGNATURE William R. Lupton MD   |  | 23B. DATE SIGNED 1/27/72   |  | 23C. PHYSICIAN'S NAME (Type) William R. Lupton MD  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial   |  | 24B. DATE 1/28/72  |  | 24C. NAME OF CEMETERY OR CREMATORY Gardens of Faith  |  |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 27 1972   |  | 25B. NAME OF REGISTRAR Robert E. Taylor, M.D.  |  | 25C. FUNERAL DIRECTOR Joseph N. Zannino, 263 S. Conkling St.   |  |

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

15. 10. 55

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |          |  |   |  |   |  |
|---|--|----------|--|---|--|---|--|
| M-250   |  | 72 00913 |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 72 00913   |  |
| BIRTH NO.   |  |          |  | CERTIFICATE OF DEATH  |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) MASON, Mrs. PEARL  |  |          |  | 2. DATE AND HOUR OF DEATH<br>1/20/72 6:00 P.M.  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |          |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE B. COUNTY |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>Church home & Hospital<br>100 BROADWAY ST. Baltimore, MD<br>35  |  |          |  | C. CITY OR TOWN<br>city.  |  |   |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |          |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>               |  |   |  |
| 5. SEX<br>F   |  |          |  | 6. RACE<br>WHITE  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOME MAKER   |  |          |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 8. DATE OF BIRTH<br>01/28/06  |  |
| 11. BIRTHPLACE (State or foreign country)<br>MD.  |  |          |  | 9. AGE (In years last birthday)<br>65   |  | 12. CITIZEN OF WHAT COUNTRY?<br>AMERICAN  |  |
| 13. FATHER'S NAME<br>CHRISTIAN  |  |          |  | 14. MOTHER'S MAIDEN NAME<br>AMANDA COLE   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  |          |  | 16. SOCIAL SECURITY NO.<br>216 073201   |  | 17. INFORMANT<br>SON - Mr. Ewell  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>HEPATIC DECOMPENSATION -   |  |          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 month   |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |          |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>CARRBOOS OF LIVER<br>CHRONIC ALCOHOLISM.          |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |          |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>Probable Ca of the Lungs -<br>metastatic primary.                    |  |   |  |
| 19A. DATE OF OPERATION  |  |          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  |          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                    |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  |          |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 1/20/72 19 to 1/20/72 19<br>that (I) (we) last saw the deceased alive on 1/20/72 19 and that (n) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |          |  |   |  |   |  |
| 23A. SIGNATURE<br>Gemma P. N. Dolos MD  |  |          |  | 23B. DATE SIGNED<br>1/20/72   |  | 23C. PHYSICIAN'S NAME (Type)<br>GEMMA P. N. DOLOS MD  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  |          |  | 24B. DATE<br>1/24/72  |  | 24C. NAME OF CEMETERY or CREMATORY<br>Baito. Cem.   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>JAN 27 1972  |  |          |  | 25B. NAME OF REGISTRAR<br>Joseph D. Zannone   |  | 25C. FUNERAL DIRECTOR<br>263 S. Calley St   |  |

1000 50

1000 50

1000 50

1000 50

1000 50

1000 50

1000 50

1000 50

1000 50

1000 50

1000 50



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |  |   |  |  |  |
|---|--|---|--|---|--|--|--|
| BIRTH NO. <b>U W-200</b>  |  | <b>72 00914</b>   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <b>72 00914</b>   |  |
| 1. NAME OF DECEASED<br>(Type or print) <b>WIFE Catherine O</b>  |  |   |  | 2. DATE AND HOUR OF DEATH<br><b>1/24/72</b> <b>17<sup>00</sup> A</b> M.   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>33 The Johns Hopkins Hospital</b>   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2634</b>                  |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. RACE<br><b>Cauc.</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>2/10/97</b>   |  |
| 9. AGE (In years last birthday) <b>74</b>   |  | 10. Under 1 Yr. Months Days   |  | 11. Under 24 Hrs. Hours Min.  |  | 12. CITIZEN OF WHAT COUNTRY<br><b>U.S.A.</b>                                       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>housewife</b>   |  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>home</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Balto.</b>                         |  |
| 13. FATHER'S NAME<br><b>James Toole</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Elizabeth Niah</b>   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  |   |  | 16. SOCIAL SECURITY NO.<br><b>217-07-8160</b>   |  | 17. INFORMANT<br><b>Mrs. Anders</b>  |  |
| 18. <b>410.01</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>cardiac arrest</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>m.c.</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>HASCPD</b><br>(C) _____                  |  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |  |
| 19A. DATE OF OPERATION<br><b>1/23</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Supra</b>  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>YES</b> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1/24</b> 19 <b>72</b> to <b>1/24</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/24</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                         |  |   |  |   |  |  |  |
| 23A. SIGNATURE<br><b>Penelope R. Scott</b>  |  |   |  | 23B. DATE SIGNED<br><b>1/24/72</b>  |  | 23C. PHYSICIAN'S NAME (Type)<br><b>Penelope R. Scott, MD</b>                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  |   |  | 24B. DATE<br><b>1/27/72</b>   |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Glen Haven Memorial Park</b>              |  |
| 24D. LOCATION<br><b>Baltimore, Md.</b>  |  |   |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1972</b>   |  |  |  |
| 25B. NAME OF REGISTRAR<br><b>Joseph N. Zannino</b>  |  |   |  | 25C. FUNERAL DIRECTOR<br><b>Joseph N. Zannino, 263 S. Conkling St.</b>  |  |  |  |

1000 ST

1000 ST

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO. <span style="float: right;">X-216</span>  |  | 72 00915 CERTIFICATE OF DEATH   |   | REG. NO. 72 00915   |   |
|---|--|---|---|---|---|
| 1. NAME OF DECEASED<br>(Type or Print) <b>HELENA KISPERT</b>  |  |   | 2. DATE AND HOUR OF DEATH<br><b>1-25-72 2:55 P.M.</b>                                 |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Church Home &amp; Hospital</b><br><b>100 N. Broadway</b><br><b>Baltimore MD 21231</b>  |  |   | A. STATE <b>MD.</b><br>B. COUNTY <b>2611</b>  |   |   |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |   | C. CITY OR TOWN<br><b>Baltimore</b>   |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 5. SEX <b>Female</b> RACE <b>White</b>  |  |   | E. STREET AND NUMBER<br><b>3204 Fleet St. #21224</b>                                  |   |   |
| 6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |   | 8. DATE OF BIRTH<br><b>08-22-81</b>   |   | 9. AGE (In years last birthday)<br><b>86</b>  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |  |   | 11. BIRTHPLACE (State or foreign country)<br><b>MD., BALTIMORE</b>                    |   | 12. CITIZEN OF WHAT COUNTRY?<br><b>American</b>   |
| 10B. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  |   |   |   |   |
| 13. FATHER'S NAME<br><b>AUGUST MUELLER</b>  |  |   | 14. MOTHER'S MAIDEN NAME<br><b>MARGARET RAUH</b>                                      |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   | 16. SOCIAL SECURITY NO.<br><b>NONE</b>  |   | 17. INFORMANT<br><b>A. Sowa - Nurse Church Home &amp; Hosp.</b>                               |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>412.4 I</b><br><b>Cerebrovascular accident</b>  |  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br><b>C-H-F - R - Rectal Bleeding</b>   |  |   | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>A-S-C-V-D</b>               |   |   |
|   |  |   | (B) DUE TO, OR AS A CONSEQUENCE OF:   |   |   |
|   |  |   | (C)   |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  |   |   |   |   |
| 19A. DATE OF OPERATION<br><b>None</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>None</b>   |   | 20A. AUTOPSY? (Yes or No)<br><b>None</b>  |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |   |   |   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><b>None</b>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)<br><b>None</b>    |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br><b>None</b> |   |
| 21D. TIME OF INJURY (APPROX.)<br><b>None</b>  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   | 21F. HOW DID INJURY OCCUR?<br><b>None</b>   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1-15-1972</b> to <b>1-25-1972</b> that (I) (we) last saw the deceased alive on <b>1-25-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |   |   |   |
| 23A. SIGNATURE<br><b>Satpal Singh</b>   |  |   | 23B. DATE SIGNED<br><b>1.25.72</b>  |   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>SATPAL SINGH M.D.</b>  |  |   | 23D. ADDRESS<br><b>CHURCH HOME &amp; HOSPITAL</b>                                     |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 24B. DATE<br><b>1-28-72</b>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>SACRED HEART CEM.</b>                          |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>7401 GERMAN HILL RD. BALTO, CO., MD.</b>  |  |   |   |   |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1972</b>   |  | 25B. NAME OF REGISTRAR<br><b>Charles K. Giller</b>  |   | 25C. FUNERAL DIRECTOR ADDRESS<br><b>901 S. CONKLING ST. BALTO., MD.</b>                 |   |

21000

21000

21000

21000

21000

72 00916

BALTIMORE CITY HEALTH DEPARTMENT

72 00916

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

BIRTH NO.

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOHN BERNARD SULLIVAN</b><br><b>John Sullivan</b>  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>1 25 72</b> M. |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL (If not in hospital or institution, give street address or location)<br><b>00 3315 Schuck Street</b><br><b>Balto., 21224, Md.</b>  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>1 25 72 6:06 p.</b> M.  |  |
| 6. SEX<br><b>male</b>  |  | 7. RACE<br><b>White</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | C. CITY OR TOWN<br><b>Balto.</b>   |  |
| 9. DATE OF BIRTH<br><b>Oct. 31, 1929</b>   |  | 10. AGE (In years last birthday)<br><b>42</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Md.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>Edward T. Sullivan</b>   |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Catherine A. Mahoney</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                         |  |
| 17. SOCIAL SECURITY NO.<br><b>216-24-2969</b>  |  | 18. INFORMANT<br><b>Rita V. Sullivan</b>   |  |
| 19. <b>5-71-81</b>   |  | CAUSE OF DEATH<br><b>Fatty metamorphosis of liver</b>  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:  |  |
|  |  | (C) DUE TO, OR AS A CONSEQUENCE OF:  |  |
| 20A. DATE OF OPERATION<br><b>21</b>  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 21. AUTOPSY? (Yes or No)<br><b>yes</b>   |  |  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |  |  |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>                                    |  |
| 22F. HOW DID INJURY OCCUR?   |  |  |  |
| 23.<br>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b><br>EXAMINER'S NAME (Type)<br>DATE SIGNED <b>1/26/72</b> |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>1-29-72.</b>   |  |
| 24C. NAME of CEMETERY or CREMATORY<br><b>Sacred Heart Cemetery</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>7401 German Hill Rd., Ba. Co., Md.</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1972</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>  |  |
| 25C. FUNERAL DIRECTOR<br><b>Charles S. Seiler</b>  |  | 25D. ADDRESS<br><b>901 S. Conkling St. Balto., 21224, Md.</b>  |  |

010000

010000

UNITED STATES DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION

REPORT OF INVESTIGATION  
OF THE

NAME OF SUBJECT  
ADDRESS  
CITY  
STATE  
ZIP

DATE OF INVESTIGATION

REPORT OF INVESTIGATION

*[Handwritten signature]*

Special Agent in Charge

1-11-61

MAK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| F-363   |  | 72 00917   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 72 00917  |  |
| BIRTH NO.   |  |  |  | 1. NAME OF DECEASED<br>(Type or Print) EDWARDS, JULIA CATHERINE  |  |  |  |
| 2. DATE AND HOUR OF DEATH<br>JANUARY 25, 1972 7:30 P. M.  |  |  |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>40 ST AGNES HOSPITAL<br>CATON & WILKENS AVE |  |  |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE MARYLAND<br>C. CITY OR TOWN BALTIMORE<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  | 5. SEX FEMALE  |  | 6. RACE CAUCASIAN  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  |
| 8. DATE OF BIRTH 8/27/99  |  | 9. AGE (In years last birthday) 72   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE   |  | 10B. KIND OF BUSINESS OR INDUSTRY AT HOME  |  |
| 11. BIRTHPLACE (State or foreign country) VIRGINIA  |  | 12. CITIZEN OF WHAT COUNTRY? U.S.A.  |  | 13. FATHER'S NAME WILLIAM SHIRKEY  |  | 14. MOTHER'S MAIDEN NAME AMANDA HASS   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) NO   |  | 16. SOCIAL SECURITY NO. 213-12-3155A   |  | 17. INFORMANT BALTIMORE, MARYLAND 21229 ST AGNES HOSPITAL CATON & WILKENS AVE  |  | ADDRESS  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH Cordis over<br>DUE TO, OR AS A CONSEQUENCE OF: Acute enteroseptal myocardial infarction<br>ANTECEDENT CAUSES DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. ASCVD<br>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). Obesity<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr<br>18 hrs |  | 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No) NO   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  | 22. I certify that (X) (this hospital) attended the deceased from JANUARY 25 19 72 to JANUARY 25 19 72 that (X) (we) last saw the deceased alive on JANUARY 25 19 72 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) did (XXXX) view the body after death. |  |
| 23A. SIGNATURE [Signature]  |  | 23B. DATE SIGNED 1/26/72   |  | 23C. PHYSICIAN'S NAME (Type) JOSE APTER, M.D.  |  | 23D. ADDRESS ST AGNES HOSPITAL   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) buried   |  | 24B. DATE 1/29/72  |  | 24C. NAME OF CEMETERY OR CREMATORY Meadowridge Cem.  |  | 24D. LOCATION (City, town, or county) (State) Drossy Ind   |  |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 27 1972   |  | 25B. NAME OF REGISTRAR [Signature]   |  | 25C. FUNERAL DIRECTOR [Signature]  |  | 25D. ADDRESS 901 Hollins St. Balto 23  |  |

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000

14-00000



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |  |  |  |   |  |  |  |
|---|--|---|--|--|--|---|--|--|--|
| 7-630   |  | 72 00918  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | CERTIFICATE OF DEATH  |  | REG. NO. 72 00918                                      |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>FORD, HARRY E.</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>1/22/72 1855 P.M.</b>   |  |  |  |   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br><b>34 Bon Secours Hospital</b>  |  |   |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE <b>MARYLAND</b> COUNTY <b>BALTO MD</b> ZIP <b>21223 2005</b> |  |   |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>34 Bon Secours Hospital</b>  |  |   |  | C. CITY OR TOWN<br><b>Baltimore</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |  |  |
| 5. SEX <b>M</b>   |  |   |  | 6. RACE <b>W</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>7/16-95</b>                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  |   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>0</b>  |  | 9. AGE (In years last birthday) <b>76</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>MD</b> |  |
| 13. FATHER'S NAME<br><b>Lawrence Ford</b>   |  |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Jennie (Unknown)</b>  |  |   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   |  | 16. SOCIAL SECURITY NO.<br><b>70505890</b>   |  | 17. INFORMANT<br><b>Mr. Kenneth O. Ford, 6 McTavish Ave. 21228</b>  |  |  |  |
| 18. <b>492X1</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)<br><b>Congestive heart failure</b>   |  |   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>day</b>   |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH           |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Chronic cor pulmonale year</b>   |  |   |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>year</b>   |  |   |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>II</b><br><b>Malnutrition + anemia year</b>  |  |   |  | (C) <b>year</b>  |  |   |  |  |  |
| 19A. DATE OF OPERATION<br><b>2/1</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>yes</b>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>yes</b>  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |  |   |  |  |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |   |  |  |  |
| 22. I certify that (X) (this hospital) attended the deceased from <b>January 20 1972</b> to <b>January 22 1972</b> that (X) (we) lost saw the deceased alive on <b>January 22 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |  |  |   |  |  |  |
| 23A. SIGNATURE<br><b>Thien Thivivara</b>  |  |   |  | 23B. DATE SIGNED<br><b>January 22, 1972</b>  |  |   |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>THIEN THIVIVARANA</b>  |  |   |  | 23D. ADDRESS<br><b>BON SECOURS HOSPITAL</b>  |  |   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>1-26-1972</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Mt. Olivet Cemetery</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>   |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 27 1972</b>   |  | 25B. NAME OF REGISTRAR<br><b>Howard H. Hubbard</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Howard H. Hubbard, 4107 Wilkens Ave. 21229</b>   |  |   |  |  |  |

218. 56

218. 56

218. 56

218. 56

218. 56

218. 56

218. 56

218. 56

218. 56

218. 56

218. 56

218. 56

218. 56

218. 56

218. 56

218. 56

218. 56

218. 56

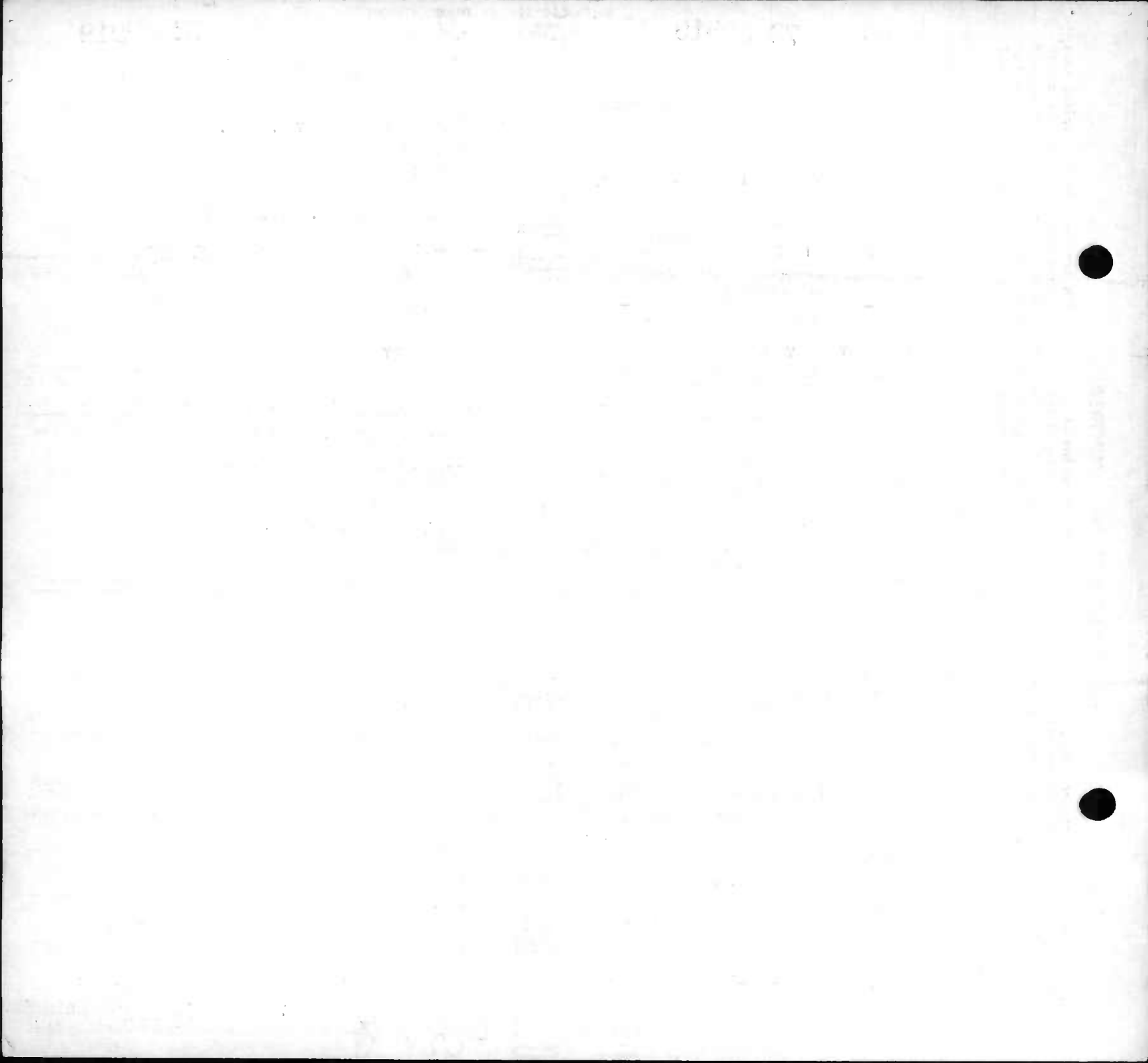
218. 56

218. 56

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. <b>72 00919</b>  |
|---|--|--|--|---|
| BIRTH NO. <b>G-160 72 00919</b>   |  | 1. NAME OF DECEASED<br>(Type or Print) <b>AUDREY GOVER</b>   |  |   |
| 2. DATE AND HOUR OF DEATH<br><b>1-21-72 3:30 P</b>  |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION <b>THE JOHNS HOPKINS HOSPITAL</b><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION) |  |   |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>BALTO. Co.</b>   |  | 5. SEX <b>FEMALE</b> 6. RACE <b>WHITE</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>       |  |   |
| C. CITY OR TOWN <b>UPPERCO</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  | 8. DATE OF BIRTH <b>6-27-71</b> 9. AGE (In years last birthday) <b>6</b> 10. MONTHS <b>25</b> 11. HOURS <b>0</b> 12. MIN. <b>0</b>   |  |   |
| E. STREET AND NUMBER <b>BLACK ROCK RD. Box 291 A</b>  |  | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>-</b> 10B. KIND OF BUSINESS OR INDUSTRY <b>-</b>  |  |   |
| 11. BIRTHPLACE (State or foreign country) <b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |   |
| 13. FATHER'S NAME <b>WILBERT GOVER</b>  |  | 14. MOTHER'S MAIDEN NAME <b>NANCY Brown</b>  |  |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b>  |  | 16. SOCIAL SECURITY NO. <b>-</b>   |  | 17. INFORMANT <b>William M. Gover</b> ADDRESS <b>Hampstead, 291 A Block Rock Rd. Md.</b>            |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CONGESTIVE HEART FAILURE - SEVERE HYPOXIA</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>POST-WATERSON SHUNT FOR TRICUSPID ATRESIA</b>  |  |   |
| (B) DUE TO, OR AS A CONSEQUENCE OF:   |  | (C) _____  |  |   |
| II  |  |  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |   |
| 19A. DATE OF OPERATION <b>6/28/71</b>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>TRICUSPID ATRESIA</b>  |  | 20A. AUTOPSY? (Yes or No) <b>YES</b>  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |  |  |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                            |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>1:45 PM 1/21 19 72</b> to <b>3:30 1/21 19 72</b> that (1) (we) last saw the deceased alive on <b>3:30 PM 1/21 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death. |  |  |  |   |
| 23A. SIGNATURE <b>Stuart Broske MD</b>  |  | 23B. DATE SIGNED <b>1/21/72</b>  |  |   |
| 23C. PHYSICIAN'S NAME (Type) <b>STUART BROSKE MD</b>  |  | 23D. ADDRESS <b>Johns Hopkins Hosp.</b>  |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>  |  | 24B. DATE <b>1-25-72</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY <b>Mt. Carmel Cemetery</b>                                       |
| 24D. LOCATION (City, town, or county) <b>Parkton Baltimore Maryland</b>   |  |  |  |   |
| 25A. DATE REC'D BY HEALTH DEPT. <b>JAN 27 1972</b>  |  | 25B. NAME OF REGISTRAR <b>John C. Goffy, M.D.</b>  |  | 25C. FUNERAL DIRECTOR <b>J. C. Goffy &amp; Son</b> ADDRESS <b>324 North Main St. Hampstead, Md.</b> |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

**BALTIMORE CITY HEALTH DEPARTMENT**

**CERTIFICATE OF DEATH**

REG. NO. **72 00920**

**S-542** **72 00920**

BIRTH NO.

1. NAME OF DECEASED  
(Type or Print) **MRS. GRACE T. SHELSEY**

2. DATE AND HOUR OF DEATH  
**JAN. 24. 1972** **2:20 PM** M.

3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD

4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  
A. STATE **MARYLAND** B. COUNTY **BALTIMORE**

5. FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  
**CHURCH HOME & HOSPITAL**  
**35**

6. CITY OR TOWN **BALTIMORE**

7. INSIDE CITY LIMITS? YES ☒ NO ☐

8. STREET AND NUMBER  
**806 N. BROADWAY** **704**

9. SEX **FEMALE** 10. RACE **WHITE** 11. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ 12. DATE OF BIRTH **10/08/86** 13. AGE (In years last birthday) **86** 14. If Under 1 Yr. Months Days 15. If Under 24 Hrs. Hours Min.

16. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **HOMEMAKER** 17. KIND OF BUSINESS OR INDUSTRY **OWN HOME** 18. BIRTHPLACE (State or foreign country) **MARYLAND** 19. CITIZEN OF WHAT COUNTRY? **AMERICAN**

20. FATHER'S NAME **JOSEPH S. TYDINGS** 21. MOTHER'S MAIDEN NAME **JANE WILSON**

22. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) **NO** 23. SOCIAL SECURITY NO. **220-44-2690** 24. INFORMANT **MR. JOSEPH TYDINGS.** ADDRESS \_\_\_\_\_

25. CAUSE OF DEATH

DISEASE OR CONDITION DIRECTLY LEADING TO DEATH

(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)

ANTECEDENT CAUSES

DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

(A) IMMEDIATE CAUSE **CIRCULATING FAILURE**  
DUE TO, OR AS A CONSEQUENCE OF:

(B) **CHRONIC HEART DISEASE;  
CHRONIC RESPIRATORY OBSTRUCTION**  
DUE TO, OR AS A CONSEQUENCE OF:

(C) \_\_\_\_\_

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

II

OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  
**(a) Intestinal obstruction due to adhesions operated 1/16/72.  
(b) Carcinoma recto sigmoid resected April 1971**

19A. DATE OF OPERATION **1/16/72** 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED **INTESTINAL OBSTRUCTION** 20A. AUTOPSY? (Yes or No) **NO** 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) ☐ 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) **HOME** 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)

21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.) **1/24/72** 21E. INJURY OCCURRED While At Work ☐ Not While At Work ☒ 21F. HOW DID INJURY OCCUR? **HE SEEN SWIMMING AT DECK**

22. I certify that (I) (this hospital) attended the deceased from **1/23** 19 **72** to **1/24** 19 **72** that (I) (we) last saw the deceased alive on **19** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.

23A. SIGNATURE **A Mehta MD** 23B. DATE SIGNED **1/24/72** Attending Phys. ☐ Med. Director ☐ Staff Phys. ☒

23C. PHYSICIAN'S NAME (Type) **ASHWIN MEHTA MD** 23D. ADDRESS **Church Home Hosp.**

24A. BURIAL CREMATION, REMOVAL (Specify) **ENTOMBMENT** 24B. DATE **1/27/72** 24C. NAME OF CEMETERY OR CREMATORY **MEMORIAL PARK** 24D. LOCATION (City, town, or county) (State) **FREDERICK MD**

25A. DATE REC'D BY HEALTH DEPT. **JAN 27 1972** 25B. NAME OF REGISTRAR **Rubert E. Taber, Md** 25C. FUNERAL DIRECTOR **WINSLOW** ADDRESS **NEW**

AS 1060

AS 1060

c

*[Faint handwritten text at the bottom of the page]*

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

S-300

72 00921

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

REG. NO.

72 00921

|   |                      |  |                              |   |   |
|---|----------------------|--|------------------------------|---|---|
| BIRTH NO.   |                      | 1. NAME OF DECEASED<br>(Type or Print)   |                              | 2. DATE AND HOUR OF DEATH   |   |
|   |                      | SCOTT, MARIE PEDRICK   |                              | JANUARY 23, 1972 2:15 A.M.  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                      | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  |                              |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>40 ST AGNES HOSPITAL<br>CATON & WILKENS AVENUES<br>BALTIMORE, MARYLAND 21229  |                      | A. STATE<br>MARYLAND<br>B. COUNTY<br>21229 2864<br>C. CITY OR TOWN<br>BALTIMORE<br>D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER<br>4501 OLD FREDERICK ROAD  |                              |   |   |
| 5. SEX<br>FEMALE  | 6. RACE<br>CAUCASIAN | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br>12/21/84 | 9. AGE (in years last birthday)<br>87   | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE  |                      | 10B. KIND OF BUSINESS OR INDUSTRY<br>own home  |                              | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND   |   |
| 13. FATHER'S NAME<br>FRANK HOOPER   |                      | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |                              |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO  |                      | 16. SOCIAL SECURITY NO.<br>212-07-0028   |                              | 17. INFORMANT<br>BALTO MD 21229 ADDRESS<br>ST AGNES' RECORDS CATON & WILKENS AVES             |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (At least the UNDERLYING CONDITION last. |                      | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>CARDIAC ARRHYTHMIA DASYSTOLE<br>Myocardial Infarction.<br>ASCUT. BILAT. BRONCHOPNEUMONIA<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>TRACHEO ESOPHAGEAL FISTULA<br>(C) FRACTURE OF FEMUR<br>POLYCYTHEMIA - VERA, UGI bleeding 10 XRS.<br>RENAL INSUFFICIENCY |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>5 DAYS<br>5 DAYS<br>1 day                     |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                      |  |                              |   |   |
| 19A. DATE OF OPERATION<br>Dec-30-1972   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>Fr. of FEMUR   |                              | 20A. AUTOPSY? (Yes or No)<br>NO   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>UPLAND HOME  |                              | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)<br>BALTIMORE CITY |   |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br>Dec 27 1971   |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>   |                              | 21F. HOW DID INJURY OCCUR?<br>FALLING   |   |
| 22. I certify that (X) (this hospital) attended the deceased from DECEMBER 27 19 71 to JANUARY 23 19 72 that (X) (we) last saw the deceased alive on JANUARY 23 19 72 and that (XXX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (XXXXX) view the body after death.        |                      |  |                              |   |   |
| 23A. SIGNATURE<br>Sunthorn MacIsrie MD  |                      | 23B. DATE SIGNED<br>JAN 23, 1972   |                              | 23C. PHYSICIAN'S NAME (Type)<br>SUNTHORN MACISRIE MD  |   |
| 23D. ADDRESS<br>St Agnes Hosp   |                      | 23E. MED. DIRECTOR<br>Staff Phys. <input checked="" type="checkbox"/>  |                              |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                      | 24B. DATE<br>1-25-72   |                              | 24C. NAME OF CEMETERY or CREMATORY<br>Druid Ridge Cemetery                                    |   |
| 24D. LOCATION<br>Pikesville Md.   |                      | 25A. DATE REC'D BY HEALTH DEPT.<br>JAN 27 1972   |                              |   |   |
| 25B. NAME OF REGISTRAR<br>John J. ...   |                      | 25C. FUNERAL DIRECTOR<br>ADDRESS<br>Towson Inc. Towson Md  |                              |   |   |

11/19/66 - Adm. to N.H.

1000 1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

ST-4-1  
1000

1000

1000

1000

1000

1000

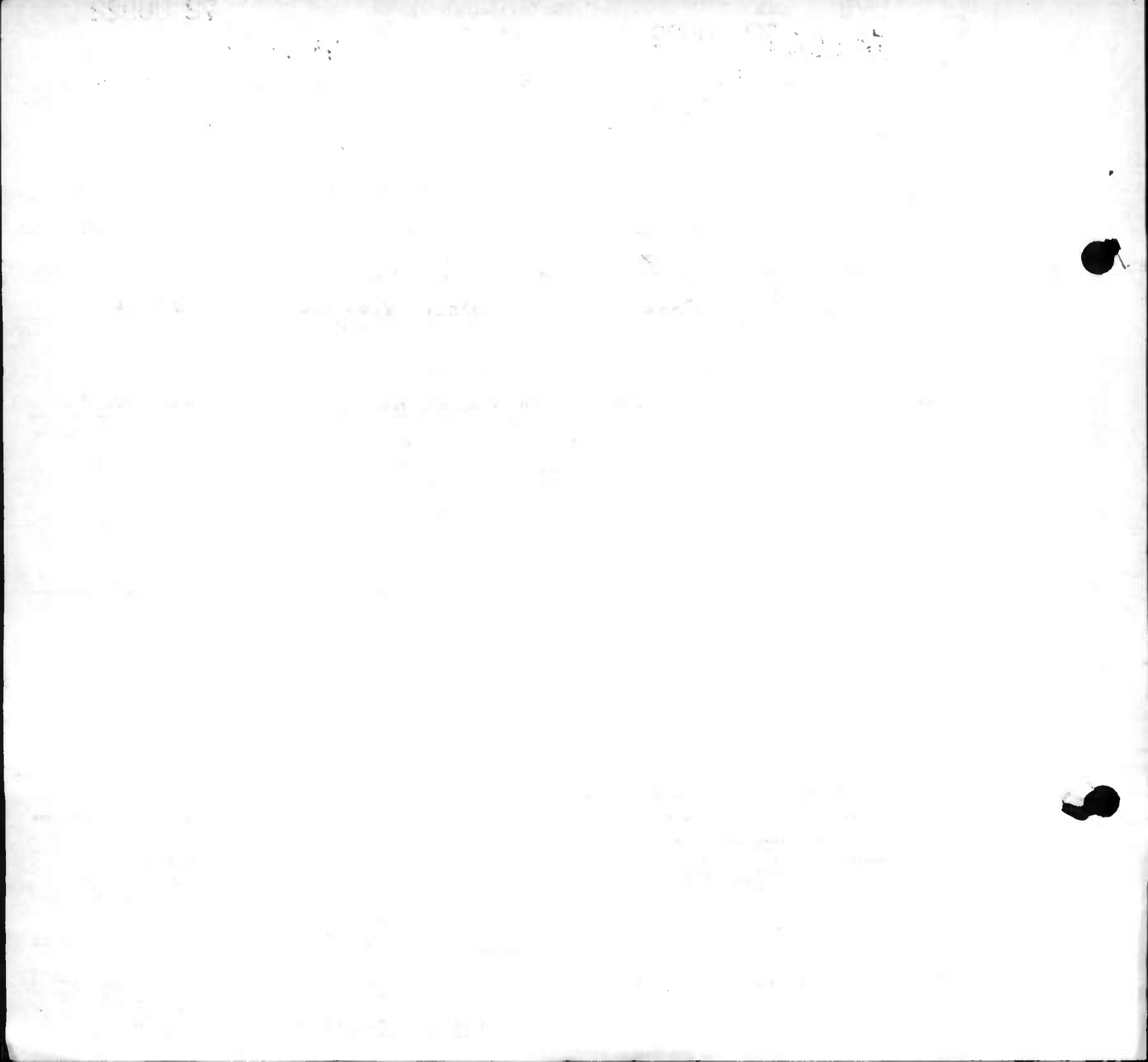
1000



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                  |   |                              |   |                             |   |  |
|---|------------------|---|------------------------------|---|-----------------------------|---|--|
| N-458   |                  | 72 00922  |                              | BALTIMORE CITY HEALTH DEPARTMENT  |                             | REG. NO. 72 00922   |  |
| BIRTH NO.   |                  |   |                              | 1   |                             |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) NEWLON, Mr. HARRY LEE  |                  |   |                              | 2. DATE AND HOUR OF DEATH<br>1/23/72 6:45 P.M.  |                             |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                  |   |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |                             |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION  |                  | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION  |                              | A. STATE<br>MD.   |                             | B. COUNTY<br>BALTIMORE 2634   |  |
| 5 Church Home & Hospital<br>100 Broadway St. 21231  |                  |   |                              | C. CITY OR TOWN<br>CITY   |                             | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER<br>935 SPANGLER WAY 21205  |                  |   |                              |   |                             |   |  |
| 5. SEX<br>MALE  | 6. RACE<br>WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>11/11/00 | 9. AGE (In years last birthday)<br>71   | 10. Under 1 Yr. Months Days | 11. Under 24 Hrs. Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>RETIRED.   |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>Cook   |                              | 11. BIRTHPLACE (State or foreign country)<br>WEST VIRGINIA                            |                             | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 13. FATHER'S NAME<br>?  |                  |   |                              | 14. MOTHER'S MAIDEN NAME<br>?   |                             |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO  |                  | 16. SOCIAL SECURITY NO.<br>236-03-0713A   |                              | 17. INFORMANT<br>JAMES NEWLON   |                             | ADDRESS<br>SANTA RAY  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>CVA. Probable hemorrhage, new episode. Acute.<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>White Thrombosis<br>CVA probably thrombotic.<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 Res.<br>12 days. |                  |   |                              |   |                             |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                  |   |                              |   |                             |   |  |
| 19A. DATE OF OPERATION  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                              | 20A. AUTOPSY? (Yes or No)   |                             | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                              | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)           |                             |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                              | 21F. HOW DID INJURY OCCUR?  |                             |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 1/10/72 19 to 1/23/72 19 that (I) (we) last saw the deceased alive on 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                  |   |                              |   |                             |   |  |
| 23A. SIGNATURE<br>D. R. V. Feldmann   |                  |   |                              | 23B. DATE SIGNED<br>1/23/72   |                             |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>D. R. V. FELDMANN MD  |                  |   |                              | 23D. ADDRESS<br>CHH   |                             |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL  |                  | 24B. DATE<br>1-26-72  |                              | 24C. NAME OF CEMETERY or CREMATORY<br>BLUMONT CEMETARY                                |                             | 24D. LOCATION (City, town, or county) (State)<br>GRAFTON W. VA.                               |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>JAN 27 1972  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor MD   |                              | 25C. FUNERAL DIRECTOR<br>Wm. Cook-Brooks  |                             | ADDRESS<br>TOWSON, Md.  |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                         |   |  |   |  |   |  |
|--|-------------------------|---|--|---|--|---|--|
| BIRTH NO. <b>C-640</b>   |                         | 72 00923  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <b>72 00923</b>  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Emma J. Crowl</i>  |                         |   |  | 2. DATE AND HOUR OF DEATH<br><i>1 - 22 - 1972</i>   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>43 South Balto. Gen. Hosp.</i>   |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>Md.</i> B. COUNTY <i>X</i><br>C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <i>1151 Riverside Avenue</i> |  |   |  |
| 5. SEX<br><i>Female</i>  | 6. RACE<br><i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>Dec. 28, 1891</i> | 9. AGE (In years last birthday)<br><i>80</i>  | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Housewife</i>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><i>Home</i>  |  | 11. BIRTHPLACE (State or foreign country)<br><i>Maryland</i>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><i>USA</i>                                  |  |
| 13. FATHER'S NAME<br><i>Robert Russell</i>   |                         |   |  | 14. MOTHER'S MAIDEN NAME<br><i>Dora Wiggington</i>  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><i>No</i>  |                         | 16. SOCIAL SECURITY NO.<br><i>- - -</i>   |  | 17. INFORMANT<br><i>Invin Crowl - 600 Brisbane Rd. City 21229</i>   |  | ADDRESS   |  |
| 18. <i>410.9 I</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><i>CAUSE OF DEATH</i><br><i>Acute Coronary Occlusion</i><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><i>Arteriosclerotic Cardiac -</i><br>(B) <i>Vascular Disease</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <i>years</i> |                         |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><i>Instant.</i>   |  |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                         |   |  |   |  |   |  |
| 19A. DATE OF OPERATION<br><i>0</i>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)   |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>May 19 71</i> to <i>1 - 22 19 72</i> that (I) (we) lost saw the deceased alive on <i>1 - 22 19 72</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                         |   |  |   |  |   |  |
| 23A. SIGNATURE<br><i>Rolando V. Goco MD</i>  |                         |   |  | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/>   |  | 23B. DATE SIGNED<br><i>1-24-72</i>  |  |
| 23C. PHYSICIAN'S NAME (Type)   |                         |   |  | 23D. ADDRESS  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                         | 24B. DATE<br><i>1-25-72</i>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><i>Glen Haven Cemetery</i>  |  | 24D. LOCATION (City, town, or county) (State)<br><i>Glen Burnie, AA Md.</i> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>JAN 27 1972</i>  |                         | 25B. NAME OF REGISTRAR<br><i>Robert E. Galt, MD</i>   |  | 25C. FUNERAL DIRECTOR<br><i>Mc Ould</i>   |  | ADDRESS<br><i>130 E. Fort Ave. City 21230</i>                               |  |

8500 ST

2000 24 100 57

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                         |   |                                    | REG. NO. <b>72 00924</b>   |
|--|-------------------------|---|------------------------------------|--|
| G-146  |                         | 72 00924  |                                    | CERTIFICATE OF DEATH   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>GABLER MR. HENRY</b>   |                         | 2. DATE AND HOUR OF DEATH<br><b>1-24-72 3:30 P.M.</b>   |                                    |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>35 CHURCH HOME HOSPITAL<br/>Church Home &amp; Hospital</b>   |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> 8. COUNTY <b>Baltimore</b><br>C. CITY OR TOWN <b>Dundalk</b> D. INSIDE CITY LIMITS?<br><b>BALTO.</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER<br><b>7300 OLD BATTLE GROVE RD.</b> |                                    |  |
| 5. SEX<br><b>Male</b>  | 6. RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><b>4-17-97</b> | 9. AGE (In years last birthday) <b>74</b>                          |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retd. Electrician</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Armco Steel Co. Electrician</b>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>MD Maryland</b>    |
| 13. FATHER'S NAME<br><b>HENRY GABLER</b>   |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>   |                                    |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |                         | 16. SOCIAL SECURITY NO.<br><b>213-10-5961</b>   |                                    |  |
| 17. INFORMANT (Wife) <b>Mrs. Helen Gabler</b>  |                         | ADDRESS<br><b>7300 Old Battle Grove Rd. Dundalk, Md. 21222</b>  |                                    |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>569.91</b><br><i>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</i><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         |   |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 hrs.</b>      |
| (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>CARDIO-RESPIRATORY FAILURE</b>  |                         |   |                                    |  |
| (B) <b>UNDETERMINED.</b><br>DUE TO, OR AS A CONSEQUENCE OF:  |                         |   |                                    |  |
| (C)  |                         |   |                                    |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                         |   |                                    |  |
| 19A. DATE OF OPERATION<br><b>1-14-72</b>   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>nonfunctioning gas no enterostomy</b>  |                                    | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH? <input type="checkbox"/><br>Notify medical examiner <input type="checkbox"/>  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>-</b>  |                                    |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br><b>-</b>   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                    |  |
| 21F. HOW DID INJURY OCCUR?<br><b>-</b>   |                         | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>(If in Baltimore City, give exact location)   |                                    |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>12/30</b> 19 <b>71</b> to <b>1/24</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/24</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                         |                         |   |                                    |  |
| 23A. SIGNATURE<br><b>Federico Zan</b>  |                         | 23B. DATE SIGNED<br><b>Jan 24, 1972</b>   |                                    | 23C. PHYSICIAN'S NAME (Type)<br><b>DR. ZIMMERMAN</b>               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Cremation</b>   |                         | 24B. DATE<br><b>1/28/72</b>   |                                    | 24C. NAME of CEMETERY or CREMATORY<br><b>Loudon Park Crematory</b> |
| 24D. LOCATION<br><b>Baltimore, Maryland</b>  |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1972</b>   |                                    |  |
| 25B. NAME OF REGISTRAR<br><b>John Doda</b>   |                         | 25C. FUNERAL DIRECTOR<br><b>Doda</b>  |                                    |  |
| ADDRESS<br><b>7922 Wise Ave. Dundalk, Md.</b>  |                         |   |                                    |  |

ASRU ST

ASRU ST

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |  |  |
|--|--|---|--|--|
| BIRTH NO. <b>R-263</b>   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <b>72 00925</b>   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>George L. Reichart</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>1/25/72 3:15 A.</b>   |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>Maryland General Hospital</b>   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY <b>Baltimore</b> |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>Maryland General Hospital</b>  |  | C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |
| 5. SEX <b>Male</b> 6. RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>4/5/14</b> 9. AGE (In years, last birthday) <b>57</b>   |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Welder</b>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Iron Works</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>             |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U. S. A.</b>  |  | 13. FATHER'S NAME<br><b>George L. Reichart</b>  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>Irene Brightwell</b>  |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>                   |  |  |
| 16. SOCIAL SECURITY NO.<br><b>218-05-0916</b>  |  | 17. INFORMANT (Wife) <b>Mrs. Catherine M. Reichart</b> ADDRESS <b>3202 Fait Ave. Balto. Md.</b>   |  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Paraneoplasia, Bladder</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>3 1/2</b>  |  |  |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Metastatic</b>  |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____  |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |  |  |
| 19A. DATE OF OPERATION<br><b>None</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                                   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Approx.)  |  | 21E. INJURY OCCURRED<br>While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                    |  | 21F. HOW DID INJURY OCCUR?   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1/25/72</b> 19 <b>72</b> to <b>1/25/72</b> 19 <b>72</b> and that (I) (we) last saw the deceased alive on <b>1/25/72</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |  |
| 23A. SIGNATURE<br><b>Louis A. Shoritz</b>  |  | 23B. DATE SIGNED<br><b>1/25/72</b>  |  | 23C. PHYSICIAN'S NAME (Type)<br><b>Louis A. Shoritz</b>                  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>1/28/72</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Cedar Hill Cemetery</b>         |
| 24D. LOCATION<br><b>Glen Burnie, Maryland</b>  |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1972</b>   |  |  |
| 25B. NAME OF REGISTRAR<br><b>John J. Duda</b>  |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>2829 Hudson St. Balto. Md</b>   |  |  |

2980. 55

2980. 55

72 41 24



**FUNERAL DIRECTOR: IMPORTANT**

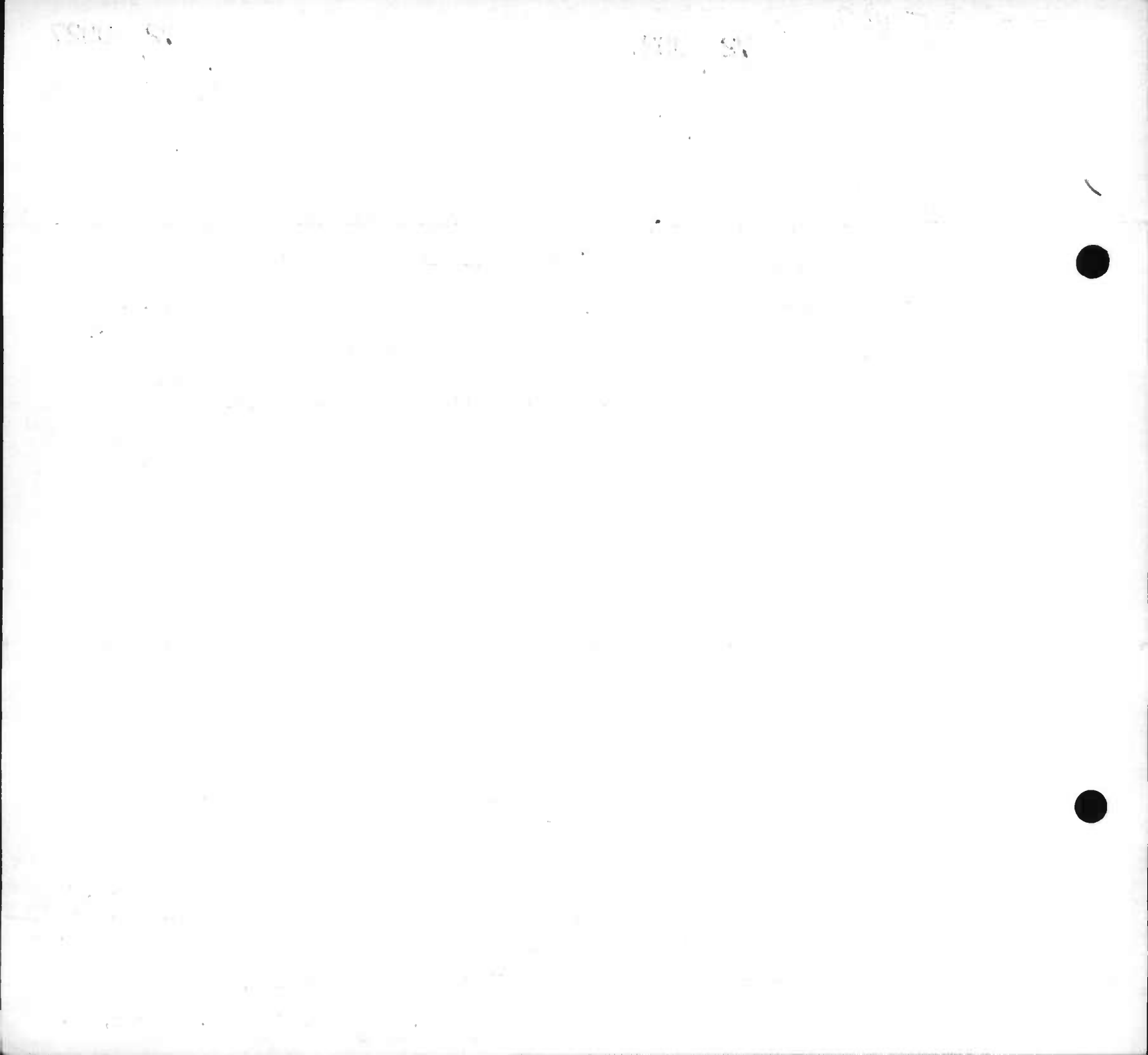
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| <p><b>S-160</b>      <b>72 00926</b></p>  |  | <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>CERTIFICATE OF DEATH</b></p>  |  | <p>REG. NO.      <b>72 00926</b></p>  |  |
| <p>BIRTH NO.</p>  |  | <p>1. NAME OF DECEASED      <b>Margaret M. Schafer</b></p> <p>(Type or Print)      <b>MARGARET SCHAFFER</b></p>   |  | <p>2. DATE AND HOUR OF DEATH</p> <p style="text-align: right;">1/25/72 1 8 <sup>45</sup>/<sub>A</sub> M.</p>  |  |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION      (If not in hospital or institution, give street address or location)</p> <p style="text-align: center;"><b>90 Gould Convalesarium</b></p>  |  | <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)</p> <p>A. STATE      <b>Maryland</b></p> <p>B. COUNTY      <b>101</b></p>  |  | <p>C. CITY OR TOWN      <b>Baltimore</b></p> <p>D. INSIDE CITY LIMITS?      YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> |  |
| <p>E. STREET AND NUMBER</p> <p style="text-align: center;"><b>806 S. Streeper Street</b></p>  |  | <p>5. SEX      <b>Female</b></p>  |  | <p>6. RACE      <b>White</b></p>  |  |
| <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>  |  | <p>8. DATE OF BIRTH      <b>Aug. 21, 1899</b></p>   |  | <p>9. AGE (In years last birthday)      <b>72</b></p>   |  |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="text-align: center;"><b>Seamstress-Robendale</b></p>   |  | <p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p style="text-align: center;"><b>Uniform Co.</b></p>  |  | <p>11. BIRTHPLACE (State or foreign country)</p> <p style="text-align: center;"><b>Maryland</b></p>   |  |
| <p>12. CITIZEN OF WHAT COUNTRY?</p> <p style="text-align: center;"><b>U. S. A.</b></p>  |  | <p>13. FATHER'S NAME</p> <p style="text-align: center;"><b>Nelson Duchesney</b></p>   |  | <p>14. MOTHER'S MAIDEN NAME</p> <p style="text-align: center;"><b>Catherine Pennington</b></p>  |  |
| <p>15. Was Deceased Ever In U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="text-align: center;"><b>No</b></p>  |  | <p>16. SOCIAL SECURITY NO.</p> <p style="text-align: center;"><b>216-18-4372A</b></p>   |  | <p>17. INFORMANT (Name and address)</p> <p style="text-align: center;"><b>(Son) 806 S. Streeper St. Baltimore, Md. 21224</b></p>                    |  |
| <p>18. <b>412.3 I</b></p> <p style="text-align: center;"><b>CAUSE OF DEATH</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)</p> <p style="text-align: center;"><b>Antisclerotic Heart Disease</b></p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="text-align: center;"><b>B. Chronic Antisclerotic</b></p> <p style="text-align: center;"><b>C. D.D. STROKE - CHRONIC BRAIN SYNDROME</b></p> |  | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>   |  |   |  |
| <p>19A. DATE OF OPERATION</p>   |  | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>   |  | <p>20A. AUTOPSY? (Yes or No)</p> <p style="text-align: center;"><b>No</b></p>   |  |
| <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>   |  | <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>  |  | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>   |  |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>   |  | <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>  |  | <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>                                |  |
| <p>21F. HOW DID INJURY OCCUR?</p>   |  | <p>22. I certify that (I) (this hospital) attended the deceased from <b>1/14/72</b> to <b>1/25/72</b></p> <p>that (I) (we) last saw the deceased alive on <b>1/18/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> |  |   |  |
| <p>23A. SIGNATURE</p> <p style="text-align: center;"><b>Albert B. Bradley</b></p>   |  | <p>23B. DATE SIGNED</p> <p style="text-align: center;"><b>1/25/72</b></p>   |  | <p>23C. PHYSICIAN'S NAME (Type)</p> <p style="text-align: center;"><b>Albert B. Bradley M. D.</b></p>   |  |
| <p>23D. ADDRESS</p> <p style="text-align: center;"><b>4900 Belair Road, Baltimore, Md.</b></p>  |  | <p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p style="text-align: center;"><b>Burial</b></p>  |  | <p>24B. DATE</p> <p style="text-align: center;"><b>1/29/72</b></p>  |  |
| <p>24C. NAME OF CEMETERY or CREMATORY</p> <p style="text-align: center;"><b>Holy Redeemer Cemetery</b></p>  |  | <p>24D. LOCATION (City, town, or county) (State)</p> <p style="text-align: center;"><b>Baltimore, Maryland</b></p>  |  | <p>25A. DATE REC'D BY HEALTH DEPT.</p> <p style="text-align: center;"><b>JAN 28 1972</b></p>  |  |
| <p>25B. NAME OF REGISTRAR</p> <p style="text-align: center;"><b>John J. Duda</b></p>  |  | <p>25C. FUNERAL DIRECTOR ADDRESS</p> <p style="text-align: center;"><b>2029 Hudson St. Balto. Md.</b></p>   |  |   |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

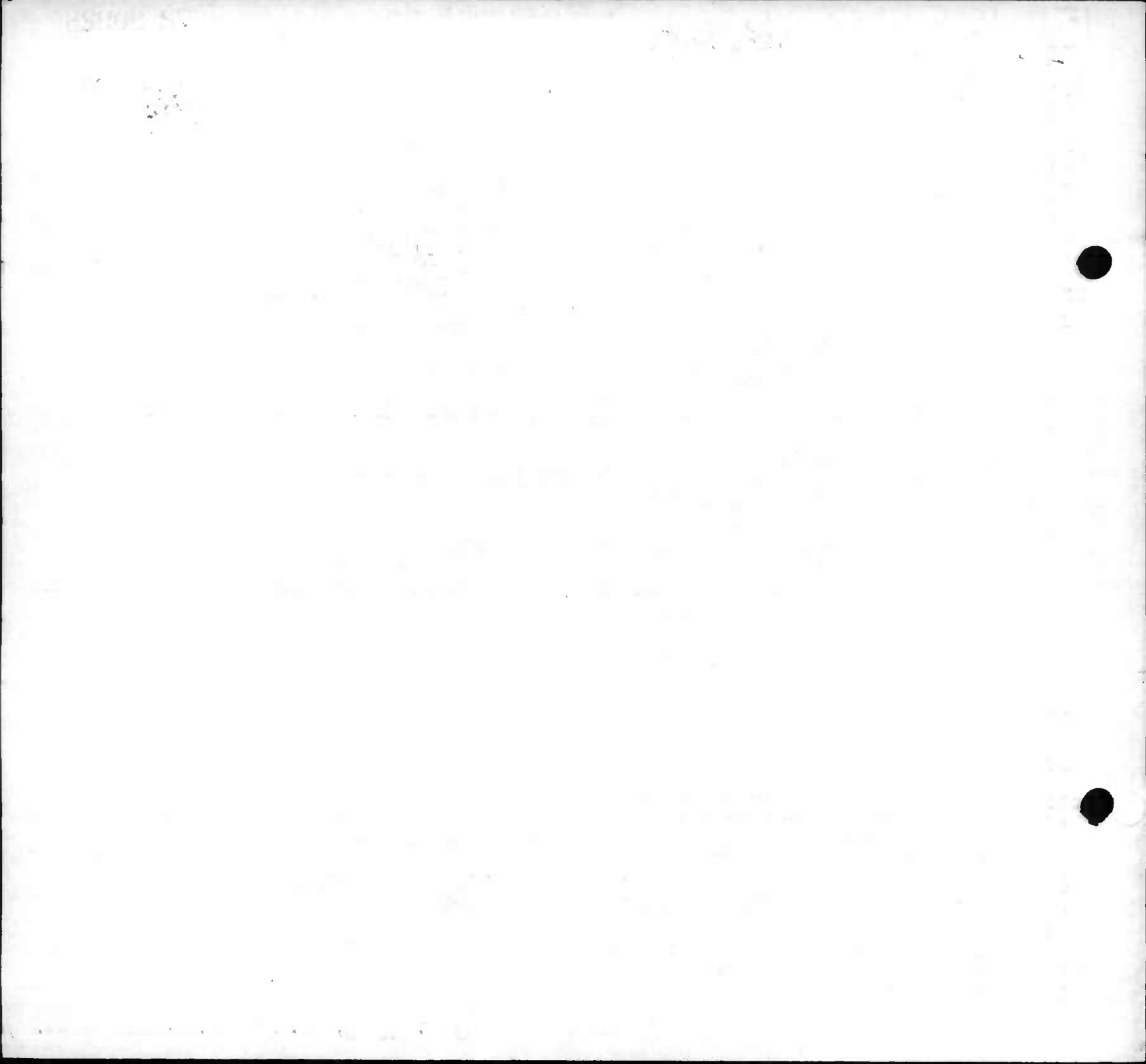
| 37-19-36  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO.  |  |
|---|--|--|--|---|--|
| BIRTH NO.   |  | 72 00927   |  | CERTIFICATE OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |  | Kay M. Ellers  |  | 2. DATE AND HOUR OF DEATH<br>1-24-72 15:30 A.M.   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE B. COUNTY  |  | Maryland BALTO 5300   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)  |  | C. CITY OR TOWN  |  | D. INSIDE CITY LIMITS?  |  |
| Baltimore City Hospitals<br>4940 Eastern Avenue<br>Baltimore, Maryland 21224  |  | Baltimore  |  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 5. SEX  |  | 6. RACE  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| Female  |  | Caucasian  |  | 8. DATE OF BIRTH<br>6-11-03   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 9. AGE (In years last birthday)<br>68   |  |
| Salesperson (Retired)   |  | May Co.  |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland   |  |
| 13. FATHER'S NAME<br>Julien Britton   |  | 14. MOTHER'S MAIDEN NAME<br>Oriole Minton  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 15. Was Deceased Ever in U. S. Armed Forces?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br>No   |  | 16. SOCIAL SECURITY NO.<br>216-32-1149   |  | 17. INFORMANT<br>4940 Eastern Avenue<br>BCH: Records Baltimore, Maryland 21224  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>Presenile dementia<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>10 years  |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br>No   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (APPROX.)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (the) (this hospital) attended the deceased from 10-6-72 to 1-24-72 that (I) (we) lost saw the deceased alive on 1-24-72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.            |  | 23A. SIGNATURE<br>Chun-shin Chiu MD  |  | 23B. DATE SIGNED<br>January 24, 1972  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>CHU-SHIN CHIU MD  |  | 23D. ADDRESS<br>4940 Eastern Avenue Baltimore, Maryland<br>Baltimore City Hospitals 21224  |  | 23E. DATE SIGNED<br>January 24, 1972  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>1-27-72   |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Loudon Park Cemetery  |  |
| 24D. LOCATION<br>Baltimore, Maryland  |  | 24E. DATE REC'D BY HEALTH DEPT.<br>JAN 28 1972   |  | 24F. NAME OF REGISTRAR<br>John J. Duda  |  |
| 24G. DATE REC'D BY HEALTH DEPT.<br>JAN 28 1972  |  | 24H. NAME OF REGISTRAR<br>John J. Duda   |  | 24I. FUNERAL DIRECTOR<br>John J. Duda   |  |
| 24J. ADDRESS<br>7922 Wise Ave. Dundalk, Md.   |  | 24K. ADDRESS<br>7922 Wise Ave. Dundalk, Md.  |  | 24L. ADDRESS<br>7922 Wise Ave. Dundalk, Md.   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BIRTH NO.   |         | BALTIMORE CITY HEALTH DEPARTMENT  |                  | REG. NO.   |
|---|---------|---|------------------|--|
| 1. NAME OF DECEASED<br>(Type or Print)  |         | 2. DATE AND HOUR OF DEATH   |                  |  |
| Blume Mr. George H.   |         | 1/24/72   |                  | 11 PM M.   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |         | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)   |                  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>CHURCH Home & Hospital<br>35 100 N. BROADWAY, BAL, MD   |         | A. STATE<br>MD.<br>B. COUNTY<br>102   |                  |  |
| IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION  |         | C. CITY OR TOWN   |                  | D. INSIDE CITY LIMITS?   |
|   |         | BALTIMORE   |                  | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>      |
| E. STREET AND NUMBER  |         |   |                  |  |
| 285 CURLEY ST. 21224  |         |   |                  |  |
| 5. SEX  | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH | 9. AGE (In years last birthday)  |
| Male  | White   |   | 03/13/1901       | 70   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY   |                  | 11. BIRTHPLACE (State or foreign country)                                |
| Retired security guard  |         | Chev. Plant   |                  | XXRX Illinois  |
| 12. CITIZEN OF WHAT COUNTRY?  |         | American  |                  |  |
| 13. FATHER'S NAME   |         | 14. MOTHER'S MAIDEN NAME  |                  |  |
| FRANK Blume   |         | Sophie Brickman   |                  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |         | 16. SOCIAL SECURITY NO.   |                  | 17. INFORMANT  |
| No  |         | 213 1045077   |                  | medical doctor   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |         | CAUSE OF DEATH  |                  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)   |         | Pulmonary embolism  |                  |  |
| ANTECEDENT CAUSES   |         | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:  |                  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |         | Arteriosclerotic CV disease   |                  |  |
|   |         | (B) DUE TO, OR AS A CONSEQUENCE OF:   |                  |  |
|   |         | Diabetes Mellitus   |                  |  |
|   |         | (C) DUE TO, OR AS A CONSEQUENCE OF:   |                  |  |
|   |         |   |                  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |         |   |                  |  |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                  | 20A. AUTOPSY? (Yes or No)  |
| No  |         |   |                  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)   |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
|   |         |   |                  |  |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED  |                  | 21F. HOW DID INJURY OCCUR?   |
| 1 Month 1 Day 1 Year 1 Hour   |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 01/23/1972 to 01/24/1972 that (I) (we) last saw the deceased alive on 19 and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |   |                  |  |
| 23A. SIGNATURE  |         | 23B. DATE SIGNED  |                  |  |
| WILMA B. MANIAGO, M.D.  |         | 1/24/72   |                  |  |
| 23C. PHYSICIAN'S NAME (Type)  |         | 23D. ADDRESS  |                  |  |
| WILMA B. MANIAGO, M.D.  |         | CHURCH HOME & HOSPITAL  |                  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |         | 24B. DATE   |                  | 24C. NAME OF CEMETERY OR CREMATORY                                       |
| Burial  |         | 1/28/72   |                  | Oak Lawn Cemetery  |
| 24D. LOCATION (City, town, or county)   |         | 24E. STATE  |                  |  |
| Baltimore, Maryland   |         |   |                  |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR  |                  | 25C. FUNERAL DIRECTOR  |
| JAN 28 1972   |         | J. E. Jones, M.D.   |                  | 3000 E. Baltimore St.  |



M-600

72 00929

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00929

BIRTH NO.

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>George Moore</b>  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>1 20 72</b>  |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Maryland State Penitentiary</b>   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>1 20 72 6:13 p.m.</b>   |  |
| 6. SEX<br><b>male</b>  |  | 7. RACE<br><b>White</b>  |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>  |  | C. CITY OR TOWN<br><b>Federalsburg</b>   |  |
| 9. DATE OF BIRTH<br><b>Aug. 29, 1913</b>   |  | 10. AGE (In years last birthday)<br><b>58</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Farmington, Delaware</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>James Moore</b>  |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>none</b>  |  |
| 15. MOTHER'S MAIDEN NAME<br><b>Clara Vosa Moore</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  |
| 17. SOCIAL SECURITY NO.<br><b>none</b>   |  | 18. INFORMANT<br><b>Mr. Harrison Moore, Federalsburg, Maryland</b>   |  |
| 19. <b>162.1 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Carcinoma of the lung with metastasis</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><b>(A) IMMEDIATE CAUSE<br/>DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(B) DUE TO, OR AS A CONSEQUENCE OF:</b><br><b>(C) DUE TO, OR AS A CONSEQUENCE OF:</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20A. DATE OF OPERATION<br><b>0</b>   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 21. AUTOPSY? (Yes or No)<br><b>no</b>  |  | 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour) (Min.)  |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>  |  |
| 22F. HOW DID INJURY OCCUR?   |  | 23.<br>I certify that I held an Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b><br>EXAMINER'S NAME (Type) |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>Jan. 23, 72</b>  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>Hillcrest Cemetery</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Federalsburg, Caroline, Md.</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1972</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert J. ...</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>Robert J. ...</b>  |  | ADDRESS<br><b>Federalsburg, Md.</b>  |  |

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000

ST 1000



A-223

72 00930

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00930

REG. NO.

BIRTH NO.

|  |  |   |  |
|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) Mildred Augustine   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/> Month 1 Day 26 Year 72 Hour M.   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>43 So. Balto. Gen. Hospital   |  | 3. DATE PRONOUNCED DEAD<br>Month 1 Day 26 Year 72 Hour 4:02 a. M.   |  |
| 6. SEX female  |  | 7. RACE White   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 5. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Md. B. COUNTY 2505  |  |
| 9. DATE OF BIRTH Sept 11, 1932   |  | 10. AGE (In years last birthday) 40   |  |
| 11. BIRTHPLACE (State or foreign country) Md   |  | 12. CITIZEN OF WHAT COUNTRY? USA  |  |
| 13. FATHER'S NAME George Ruehling (Dec)  |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk  |  |
| 15. MOTHER'S MAIDEN NAME Alice M. Waters   |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)   |  |
| 17. SOCIAL SECURITY NO.  |  | 18. INFORMANT Mrs. Edna Maton 19 W. Bristol Ave 21225   |  |
| 19. E 890X<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST. |  | CAUSE OF DEATH<br>Carbon monoxide poisoning and soot inhalation<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF:   |  |
| 20A. DATE OF OPERATION 2   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 21. AUTOPSY? (Yes or No) yes   |  | 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  |
| 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) HOUSE   |  | 22C. WHERE DID (if in Baltimore City, give exact location) INJURY OCCUR? 1425 Locust St. 2505   |  |
| 22D. TIME OF INJURY (APPROX.) 1 26 72 3:08 a.m.  |  | 22E. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |
| 22F. HOW DID INJURY OCCUR? Subject in house fire.  |  | 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> |  |
| ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.   |  | CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED 1/26/72   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial  |  | 24B. DATE 1/29/72   |  |
| 24C. NAME OF CEMETERY or CREMATORY Cedar Hill Cemetery   |  | 24D. LOCATION (City, town, or county) (State) Ritchie Hwy Balto 21225   |  |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 28 1972  |  | 25B. NAME OF REGISTRAR Robert E. Fisher, M.D.   |  |
| 25C. FUNERAL DIRECTOR McGully Funeral Home   |  | 25D. ADDRESS 237 Patapsco Ave   |  |

N 980X 20000920

98205-32

1

72 00931

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

72 00931

BIRTH NO. *New York*

REG. NO.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Steven Augustine</b>   |  |  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year Hour<br><b>1 26 72</b> M.   |  |   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>43 So. Balto. Gen. Hospital</b>  |  |  |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour<br><b>1 26 72 4:02 a.</b> M.  |  |   |  |
| 6. SEX<br><b>male</b>  |  | 7. RACE<br><b>White</b>                                |  | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | C. CITY OR TOWN<br><b>Balto.</b>  |  |
| 9. DATE OF BIRTH<br><b>August 10 1965</b>  |  | 10. AGE (In years last birthday)<br><b>6</b>           |  | If Under 1 Yr. If Under 24 Hrs.<br>Months Days Hours Min.  |  | E. STREET AND NUMBER<br><b>1425 Locust St. 21225</b>                              |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U</b>   |  | 13. FATHER'S NAME<br><b>George J. Augustine</b>                                   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  |  |  | 14B. KIND OF BUSINESS OR INDUSTRY<br><b>none</b>   |  | 15. MOTHER'S MAIDEN NAME<br><b>Mildred H Ruehling</b>                             |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)  |  |  |  | 17. SOCIAL SECURITY NO.<br><b>none</b>   |  | 18. INFORMANT ADDRESS<br><b>Edna Maton 19 Bristol Ave 21225</b>                   |  |
| 19. <b>E890X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osthenio, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |  |  |  | CAUSE OF DEATH<br><b>Carbon monoxide poisoning and soot inhalation</b><br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  |   |  |
| 20A. DATE OF OPERATION<br><b>2</b>   |  |  |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  |  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>HOUSE</b>   |  |   |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br><b>1 26 72 3:08a</b>  |  |  |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  |   |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br><b>1425 Locust St. 2505</b>  |  |  |  | 22F. HOW DID INJURY OCCUR?<br><b>Subject in house fire.</b>  |  |   |  |
| 23.<br>I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Peter Lipkovic</b> M.D.<br>EXAMINER'S NAME (Type) <b>Peter Lipkovic, M D</b><br>DATE SIGNED <b>1/26/72</b> |  |  |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>urial</b>   |  | 24B. DATE<br><b>1/29/72</b>                            |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Cedar Hill Cemetery</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Ritchie Hyway Balto 21225</b> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1972</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert J. [illegible]</b> |  | 25C. FUNERAL DIRECTOR<br><b>McGully Funeral Home</b>   |  | ADDRESS<br><b>237 Patapsco Ave</b>  |  |

1000 5

1000 5



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| W-452  |                             | 72 00932  |                                      | BALTIMORE CITY HEALTH DEPARTMENT   |  | X   |  | REG. NO. 72 00932   |  |
|--|-----------------------------|---|--------------------------------------|--|--|---|--|---|--|
| BIRTH NO.  |                             |   |                                      | 1. NAME OF DECEASED<br>(Type or Print) <b>CHARLES WILLIAMS</b>   |  |   |  | 2. DATE AND HOUR OF DEATH<br><b>1-24-72 2:50 A.M.</b>     |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Sinai Hospital of Baltimore Inc.</b>   |                             |   |                                      | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b> B. COUNTY <b>ANNE ARUNDEL</b> C. CITY OR TOWN <b>GAMBRILLS</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |   |  | E. STREET AND NUMBER<br><b>Rt. 450 Gambrells Md 21054</b> |  |
| 5. SEX<br><b>M</b>   | 6. RACE<br><b>Caucasian</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11-5-1896</b> |  | 9. AGE (In years last birthday)<br><b>75</b> |   | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Retired Printer</b>  |                             |   |                                      | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>PRINTING</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Penn.</b>                   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                |  |
| 13. FATHER'S NAME<br><b>UNK</b>  |                             |   |                                      | 14. MOTHER'S MAIDEN NAME<br><b>UNK</b>   |  |   |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>YES WW I &amp; II</b>   |                             |   |                                      | 16. SOCIAL SECURITY NO.<br><b>161-12-5004</b>  |  | 17. INFORMANT<br><b>Mrs. Agnes B. Williams, same as # 4</b>                 |  |   |  |
| 18. <b>445.91</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Cardiac arrest sec. to?</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Gangrene left foot</b> |                             |   |                                      | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Gangrene left foot</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____  |  |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH              |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).   |                             |   |                                      |  |  |   |  |   |  |
| 19A. DATE OF OPERATION<br><b>2</b>   |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                      | 20A. AUTOPSY? (Yes or No)<br><b>YES</b>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                      | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)  |  |   |  |   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |                             | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                      | 21F. HOW DID INJURY OCCUR?   |  |   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1-22-72</b> to <b>1-24-72</b> that (I) (we) last saw the deceased alive on <b>1-24-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                             |   |                                      |  |  |   |  |   |  |
| 23A. SIGNATURE<br><b>Rogelio</b>   |                             |   |                                      | 23B. DATE SIGNED<br><b>1-24-72</b>   |  |   |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>ROGELIO LIBON-ON M.D.</b>   |                             |   |                                      | 23D. ADDRESS<br><b>Sinai Hospital</b>  |  |   |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                             | 24B. DATE<br><b>Jan. 27, 72</b>   |                                      | 24C. NAME OF CEMETERY or CREMATORY<br><b>Hillcrest Memorial Cemetery</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Annapolis, Maryland</b> |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1972</b>  |                             | 25B. NAME OF REGISTRAR<br><b>Rogelio Libon-ON</b>   |                                      | 25C. FUNERAL DIRECTOR<br><b>Hopping Funeral Home</b>   |  | ADDRESS<br><b>Annapolis, Md.</b>  |  |   |  |

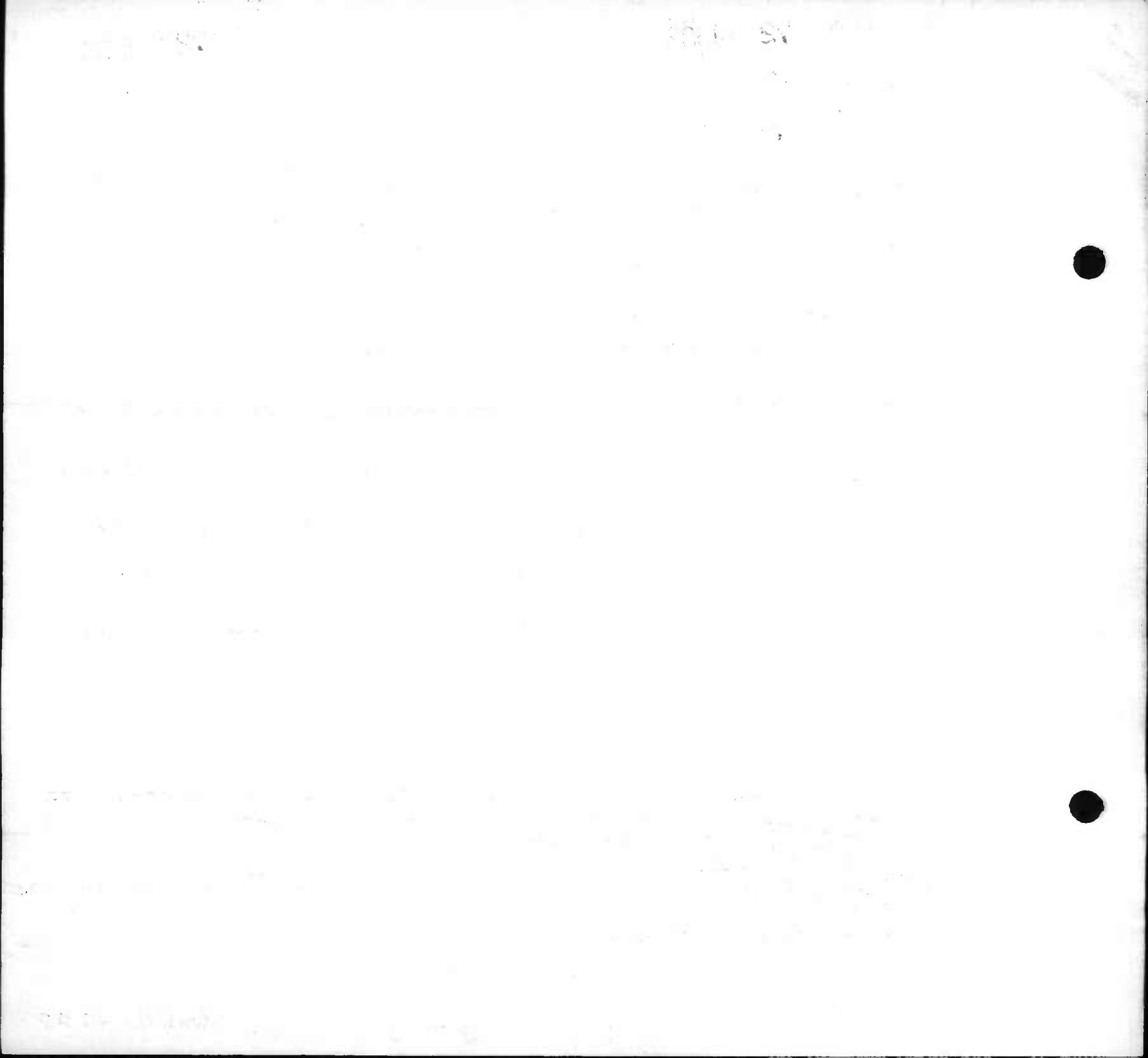
80/11 54

80/11 54

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|
| <p><b>BIRTH NO.</b> <span style="font-size: 1.5em;">M-460</span> <span style="font-size: 1.5em;">72 00933</span></p>  |  | <p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p>   |  | <p><b>CERTIFICATE OF DEATH</b></p>   |  | <p><b>REG. NO.</b> <span style="font-size: 1.5em;">72 00933</span></p>                                       |  |
| <p><b>1. NAME OF DECEASED</b><br/>(Type or Print) <u>Miller, Catherine</u></p>  |  |  |  | <p><b>2. DATE AND HOUR OF DEATH</b><br/><u>1/25/72</u> <u>6:30 P. M.</u></p>   |  |  |  |
| <p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>  |  |  |  | <p><b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution; residence before admission)<br/>A. STATE <u>MD.</u> B. COUNTY <u>Balto.</u></p>                                      |  |  |  |
| <p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b><br/><u>St. Agnes Hosp. E.R.</u><br/><u>900 S. Caton Ave 21209</u></p>  |  | <p><b>IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION</b></p>   |  | <p><b>C. CITY OR TOWN</b><br/><u>Baltimore</u></p>   |  | <p><b>D. INSIDE CITY LIMITS?</b><br/>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> |  |
| <p><b>5. SEX</b><br/><u>F</u></p>   |  | <p><b>6. RACE</b><br/><u>W</u></p>   |  | <p><b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br/><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p> |  | <p><b>8. DATE OF BIRTH</b><br/><u>1/5/81</u></p>   |  |
| <p><b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br/><u>HOUSE KEEPER</u></p>   |  | <p><b>10B. KIND OF BUSINESS OR INDUSTRY</b><br/><u>HOME</u></p>  |  | <p><b>11. BIRTHPLACE</b> (State or foreign country)<br/><u>MD.</u></p>   |  | <p><b>12. CITIZEN OF WHAT COUNTRY?</b><br/><u>U.S.A.</u></p>   |  |
| <p><b>13. FATHER'S NAME</b><br/><u>PETER LABONTE</u></p>  |  |  |  | <p><b>14. MOTHER'S MAIDEN NAME</b><br/><u>ANNA MUELLER</u></p>   |  |  |  |
| <p><b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br/><u>no</u></p>  |  | <p><b>16. SOCIAL SECURITY NO.</b><br/><u>—</u></p>   |  | <p><b>17. INFORMANT</b> <u>Mrs. Anne Conigan - 1815 Selma Ave. 21111</u></p>   |  |  |  |
| <p><b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br/>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br/><u>441.9 I</u></p>  |  |  |  | <p><b>CAUSE OF DEATH</b><br/><u>EXSANGUINATING HEMORRHAGE</u></p>  |  | <p><b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br/><u>3 HRS</u></p>                                  |  |
| <p><b>ANTECEDENT CAUSES</b><br/>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p>   |  |  |  | <p><b>(A) IMMEDIATE CAUSE</b><br/><u>RUPTURED AORTIC ANEURYSM</u></p>  |  | <p><b>YEARS</b><br/><u>—</u></p>   |  |
| <p><b>(B) OTHER CAUSE</b><br/><u>ATHEROSCLEROSIS</u></p>  |  |  |  | <p><b>YEARS</b><br/><u>—</u></p>   |  | <p><b>3 HRS</b></p>  |  |
| <p><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b><br/><u>HEMATEMESIS, CAUSE UNKNOWN</u></p>  |  |  |  | <p><b>HEMATEMESIS, CAUSE UNKNOWN</b></p>   |  | <p><b>3 HRS</b></p>  |  |
| <p><b>19A. DATE OF OPERATION</b><br/><u>none</u></p>  |  | <p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br/><u>—</u></p>  |  | <p><b>20A. AUTOPSY?</b> (Yes or No)<br/><u>NO</u></p>  |  | <p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b><br/><u>—</u></p>              |  |
| <p><b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)<br/><u>—</u></p>  |  | <p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)<br/><u>—</u></p>      |  | <p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)<br/><u>—</u></p>  |  |  |  |
| <p><b>21D. TIME OF INJURY (APPROX.)</b><br/><u>—</u></p>  |  | <p><b>21E. INJURY OCCURRED</b><br/>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p> |  | <p><b>21F. HOW DID INJURY OCCUR?</b><br/><u>—</u></p>  |  |  |  |
| <p><b>22. I certify that (1) (this hospital) attended the deceased from <u>15 JANUARY 1972</u> to <u>25 JANUARY 1972</u> that (1) (we) last saw the deceased alive on <u>25 JANUARY 1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.</b></p> |  |  |  |  |  |  |  |
| <p><b>23A. SIGNATURE</b><br/><u>[Signature]</u></p>   |  |  |  | <p><b>23B. DATE SIGNED</b><br/><u>25 JANUARY 1972</u></p>  |  | <p><b>23C. PHYSICIAN'S NAME (Type)</b><br/><u>F.N. BURT M.D.</u></p>   |  |
| <p><b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br/><u>Burial</u></p>  |  | <p><b>24B. DATE</b><br/><u>1-29-72</u></p>   |  | <p><b>24C. NAME OF CEMETERY or CREMATORY</b><br/><u>Catholic Cemetery</u></p>  |  | <p><b>24D. LOCATION</b> (City, town, or county) (State)<br/><u>Baltimore</u> <u>Ind.</u></p>                 |  |
| <p><b>25A. DATE REC'D BY HEALTH DEPT.</b><br/><u>JAN 28 1972</u></p>  |  | <p><b>25B. NAME OF REGISTRAR</b><br/><u>Robert E. Seiber, M.D.</u></p>   |  | <p><b>25C. FUNERAL DIRECTOR</b> <u>Anthony Guenough</u> <u>212 28</u></p>  |  |  |  |

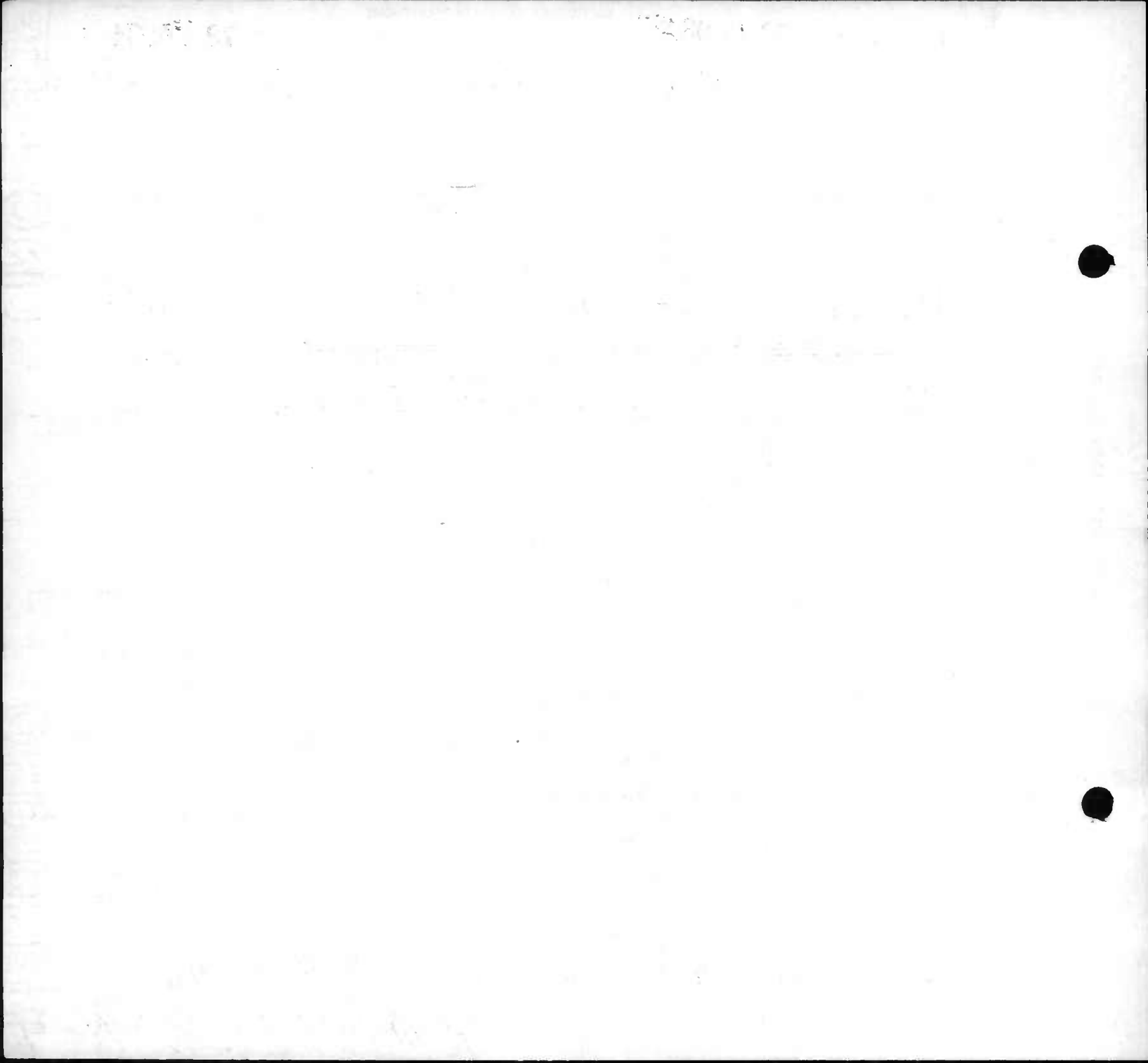




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |         |   |                              |   |                             |
|--|---------|---|------------------------------|---|-----------------------------|
| B-326 72 00934   |         | BALTIMORE CITY HEALTH DEPARTMENT  |                              | REG. NO. 72 00934   |                             |
| BIRTH NO.  |         | 1. NAME OF DECEASED<br>(Type or Print)  |                              | 2. DATE AND HOUR OF DEATH   |                             |
|  |         | MARY A BUTCHER  |                              | 1/23/72 7 <sup>50</sup> PM  |                             |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |         |   |                              | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |                             |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |         |   |                              | A. STATE  |                             |
|  |         |   |                              | B. COUNTY   |                             |
| THE UNION MEMORIAL HOSPITAL  |         |   |                              | C. CITY OR TOWN   |                             |
|  |         |   |                              | D. INSIDE CITY LIMITS?  |                             |
|  |         |   |                              | E. STREET AND NUMBER  |                             |
|  |         |   |                              | 2714  |                             |
|  |         |   |                              | Baltimore   |                             |
|  |         |   |                              | 1029 WOOD HEIGHTS AVENUE  |                             |
| 5. SEX   | 6. RACE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>   | 8. DATE OF BIRTH             | 9. AGE (In years last birthday)   | 10. Under 1 Yr. Months Days |
| FEMALE   | WHITE   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                      | 6-29-81                      | 90  |                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |         | 10B. KIND OF BUSINESS OR INDUSTRY   |                              | 11. BIRTHPLACE (State or foreign country)   |                             |
| Weaver   |         | Cotton Mill   |                              | Md  |                             |
| 13. FATHER'S NAME  |         |   | 12. CITIZEN OF WHAT COUNTRY? |   |                             |
| Robert D Butcher   |         |   | USA                          |   |                             |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |         |   | 14. MOTHER'S MAIDEN NAME     |   | ADDRESS                     |
| No   |         |   | Mary Gosnell                 |   |                             |
| 16. SOCIAL SECURITY NO.  |         |   | 17. INFORMANT                |   | ADDRESS                     |
| 215 076392   |         |   | Harry E Sterner              |   | 52 me                       |
| 18. CAUSE OF DEATH   |         |   |                              | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                             |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |         |   |                              |   |                             |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)   |         |   |                              | (A) IMMEDIATE CAUSE   |                             |
|  |         |   |                              | PULMONARY EMBOLISM  |                             |
|  |         |   |                              | DUE TO, OR AS A CONSEQUENCE OF:   |                             |
| ANTECEDENT CAUSES  |         |   |                              | (B) DUE TO, OR AS A CONSEQUENCE OF:   |                             |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |         |   |                              |   |                             |
| II   |         |   |                              |   |                             |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |         |   |                              | PNEUMONIA -   |                             |
| 19A. DATE OF OPERATION   |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                              | 20A. AUTOPSY? (Yes or No)   |                             |
|  |         |   |                              |   |                             |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)  |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.) |                              | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                             |
|  |         |   |                              |   |                             |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |         | 21E. INJURY OCCURRED  |                              | 21F. HOW DID INJURY OCCUR?  |                             |
|  |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>       |                              |   |                             |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____   |         |   |                              |   |                             |
| that (I) (we) last saw the deceased alive on _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |   |                              |   |                             |
| 23A. SIGNATURE   |         |   |                              | 23B. DATE SIGNED  |                             |
| J. A. Paz  |         |   |                              | 1/23/72   |                             |
| 23C. PHYSICIAN'S NAME (Type)   |         |   |                              | 23D. ADDRESS  |                             |
| JOSE PAZ   |         |   |                              |   |                             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |         | 24B. DATE   |                              | 24C. NAME OF CEMETERY OR CREMATORY  |                             |
| Burial   |         | 26 JAN 27   |                              | Poplar Grove Cem  |                             |
| 25A. DATE REC'D BY HEALTH DEPT.  |         | 25B. NAME OF REGISTRAR  |                              | 25C. FUNERAL DIRECTOR   |                             |
| JAN 28 1972  |         | By Norma H. Hume Jr   |                              | Burger Funeral Home   |                             |
|  |         |   |                              | Baltimore Md  |                             |



1

H-520 72 00935 BALTIMORE CITY HEALTH DEPARTMENT

MEDICAL EXAMINER'S CERTIFICATE OF DEATH 72 00935

BIRTH NO. REG. NO.

|  |  |  |  |
|--|--|--|--|
| 1. NAME OF DECEASED (Type or Print)<br>Anna Heinecke   |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Month 1 Day 25 Year 72<br>Estimated <input type="checkbox"/> Hour 2:33 A. M.   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>33 Johns Hopkins Hospital  |  | 3. DATE PRONOUNCED DEAD<br>Month 1 Day 25 Year 72 Hour 2:33 A. M.  |  |
| 6. SEX<br>Female   |  | 7. RACE<br>White   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY BALTO C. CITY OR TOWN Baltimore D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
| 9. DATE OF BIRTH<br>May 25, 1911   |  | 10. AGE (In years last birthday) 30  |  |
| 11. BIRTHPLACE (State or foreign country)<br>Virginia  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Waitress  |  | 14B. KIND OF BUSINESS OR INDUSTRY  |  |
| 15. MOTHER'S MAIDEN NAME<br>Mary Humphries   |  | 13. FATHER'S NAME<br>Earl Davis  |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |  | 17. SOCIAL SECURITY NO.<br>220 36 7719   |  |
| 18. INFORMANT<br>George M. Heinecke  |  | ADDRESS<br>Same  |  |
| 19. CAUSE OF DEATH<br>E 812.9<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 20A. DATE OF OPERATION   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>street   |  |
| 22D. TIME (Month) (Day) (Year) (Hour) OF INJURY (APPROX.)<br>1 23 72 1:10 P.M.   |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?<br>Erdman Avenue & Sinclair Lane 2655   |  |
| 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>   |  | 22F. HOW DID INJURY OCCUR?<br>Motorcycle-auto accident   |  |
| 23. I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>Deputy CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ACTUAL SIGNATURE <i>Werner U. Spitz</i> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>EXAMINER'S NAME (Type) Werner U. Spitz, M.D. ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/> |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial   |  | 24B. DATE<br>27 Jan. 1972  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br>Meadowridge Mem. Cemetery  |  | 24D. LOCATION (City, town, or county) (State)<br>Howard County, Maryland   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>JAN 28 1972   |  | 25B. NAME OF REGISTRAR<br>Robert E. Fisher, M.D.   |  |
| 25C. FUNERAL DIRECTOR<br>Burgee Funeral Home   |  | ADDRESS<br>Baltimore, Md.  |  |

VS 151-REV. 1/1/68

1889.3000 by Linda Meyer

15-00000

15-00000



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                     |   |                                    | REG. NO. <span style="float: right;">72 00936</span>                        |   |
|---|---------------------|---|------------------------------------|---|---|
| H-252 72 00936  |                     | CERTIFICATE OF DEATH  |                                    |   |   |
| BIRTH NO. 72-02110  |                     | 1. NAME OF DECEASED <u>Marie Adele HIGGINS</u>  |                                    |   |   |
| 2. DATE AND HOUR OF DEATH<br><u>1/24/72</u>   |                     | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><u>UNION MEMORIAL HOSPITAL</u>  |                                    |   |   |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>BALTO</u>  |                     | 5. FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>UNION MEMORIAL HOSPITAL</u>                  |                                    |   |   |
| C. CITY OR TOWN<br><u>TOWSON</u>  |                     | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |                                    |   |   |
| E. STREET AND NUMBER<br><u>8205 CARBRIDGE CIRCLE</u>  |                     |   |                                    |   |   |
| 6. SEX<br><u>F</u>  | 7. RACE<br><u>W</u> | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>     | 9. DATE OF BIRTH<br><u>1/23/72</u> |   | 10. AGE (in years last birthday)<br><u>21</u> <u>42</u> |
| 11. BIRTHPLACE (State or foreign country)<br><u>MD.</u>   |                     | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |                                    |   |   |
| 13. FATHER'S NAME<br><u>CRAIG S. HIGGINS</u>  |                     | 14. MOTHER'S MAIDEN NAME<br><u>SUZANNE HIGGINS</u>  |                                    |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>   |                     | 16. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT<br><u>Craig S. Higgins</u>                                    |   |
| 18. <u>776.21</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>RESPIRATORY DISTRESS SYNDROME</u>   |                     | 19. CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>PREMATURITY</u><br>(B) _____<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                                |   |
| 20. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><u>II</u>   |                     |   |                                    |   |   |
| 21A. DATE OF OPERATION<br><u>2</u>  |                     | 21B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |   |
| 21D. TIME OF INJURY (APPROX.)<br>1 (Month) 1 (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                    | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <u>23 January 1972</u> to <u>24 January 1972</u> that (I) (we) last saw the deceased alive on <u>24 January 1972</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |   |                                    |   |   |
| 23A. SIGNATURE<br><u>Joan M. Reese, M.D.</u>  |                     | 23B. DATE SIGNED<br><u>24 January 1972</u>  |                                    | 23C. PHYSICIAN'S NAME (Type)<br><u>JOAN M. REESE, M.D.</u>                  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Cremation</u>  |                     | 24B. DATE<br><u>27 Jan 72</u>   |                                    | 24C. NAME of CEMETERY or CREMATORY<br><u>Greenmount Crematory</u>           |   |
| 24D. LOCATION<br><u>Baltimore, Md.</u>  |                     | 24E. NAME OF REGISTRAR<br><u>James E. Taylor, M.D.</u>  |                                    | 24F. FUNERAL DIRECTOR<br><u>Burgess Funeral Home</u>                        |   |
| 24G. DATE REC'D BY HEALTH DEPT.<br><u>JAN 28 1972</u>   |                     | 24H. NAME OF REGISTRAR<br><u>James E. Taylor, M.D.</u>  |                                    | 24I. ADDRESS<br><u>Balto, Md.</u>   |   |

20000 ST 0 0

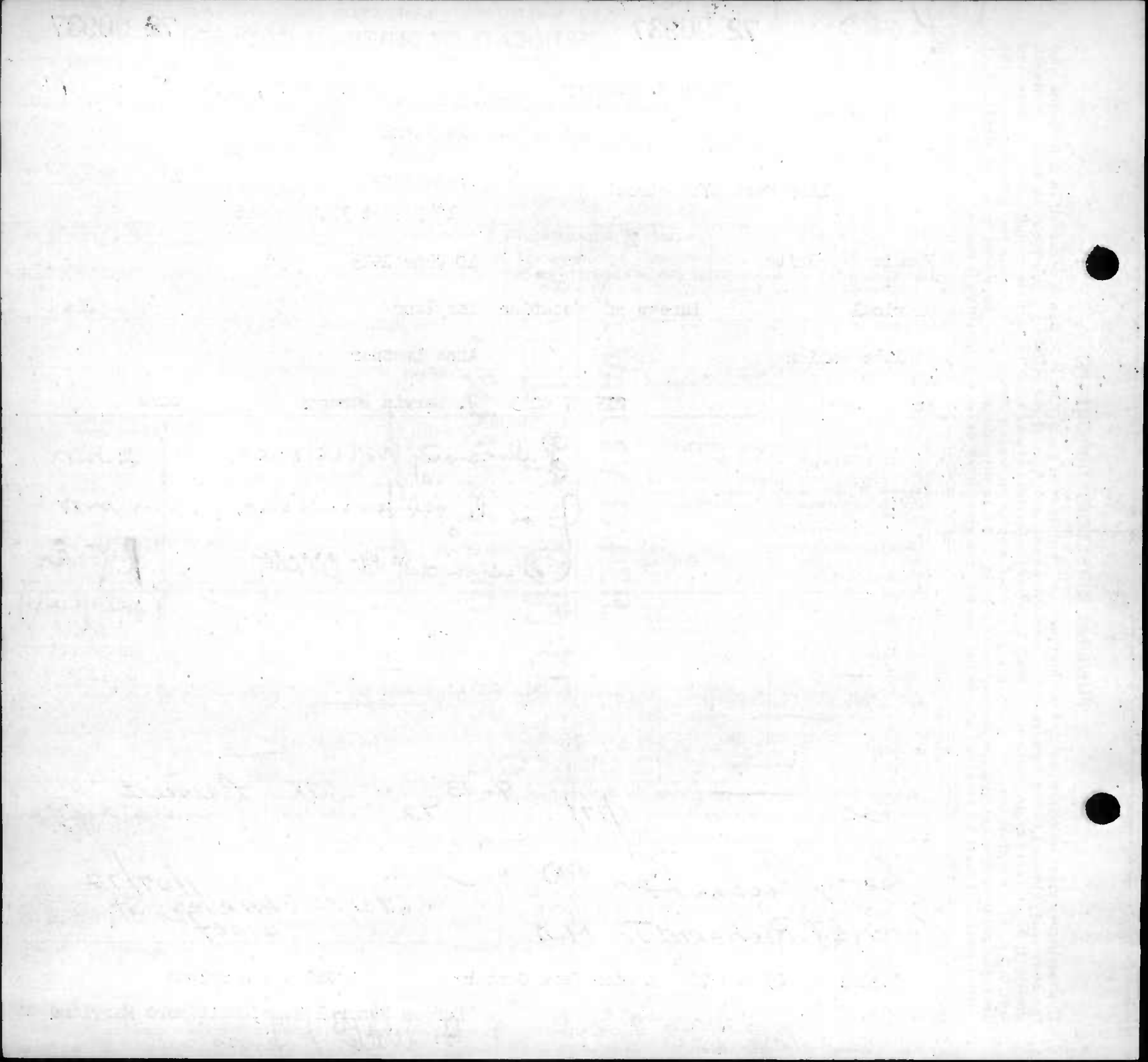
00000 ST 0 0



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

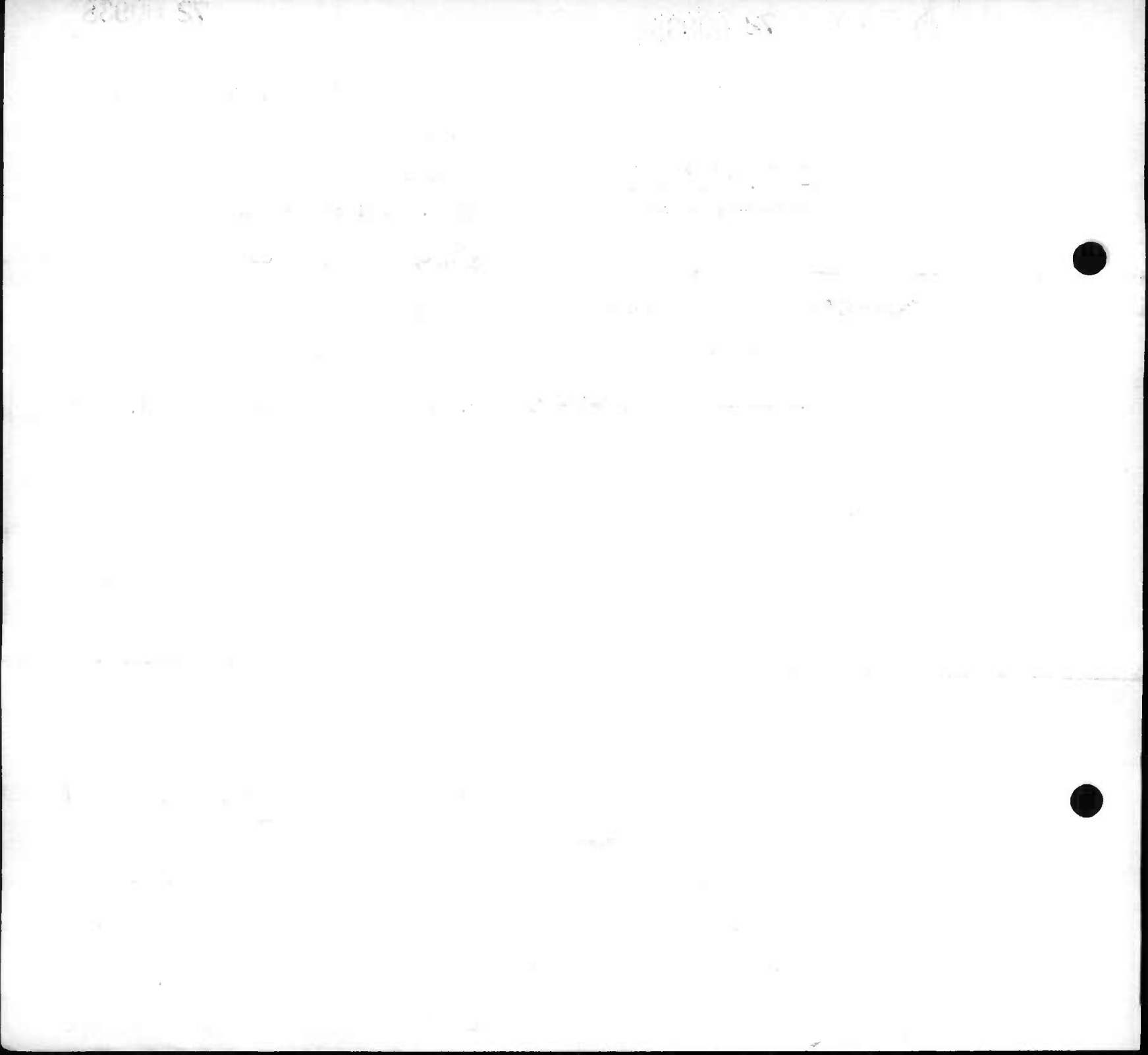
|   |  |  |  |   |   |
|---|--|--|--|---|---|
| <p style="font-size: 24pt; margin: 0;">P-620</p> <p style="font-size: 24pt; margin: 0;">72 00937</p>  |  | <p style="font-size: 24pt; margin: 0;">BALTIMORE CITY HEALTH DEPARTMENT</p> <p style="font-size: 24pt; margin: 0;">CERTIFICATE OF DEATH</p>  |  | <p style="font-size: 24pt; margin: 0;">REG. NO. 72 00937</p>  |   |
| <p>BIRTH NO.</p>  |  | <p>1. NAME OF DECEASED<br/>(Type or Print)</p> <p style="text-align: center; font-size: 18pt;">Helen H. Peregoy</p>  |  | <p>2. DATE AND HOUR OF DEATH</p> <p style="text-align: center; font-size: 18pt;">January 25, 1972 9 P.M.</p>  |   |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>   |  | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)</p> <p>A. STATE <span style="font-size: 18pt;">Maryland</span><br/>B. COUNTY <span style="font-size: 18pt;">1348</span></p> |  | <p>C. CITY OR TOWN <span style="font-size: 18pt;">Baltimore</span><br/>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> |   |
| <p>FULL NAME OF HOSPITAL OR INSTITUTION</p> <p style="font-size: 24pt;">00</p> <p style="font-size: 18pt;">1249 West 37th Street</p>  |  | <p>E. STREET AND NUMBER</p> <p style="font-size: 18pt;">1249 West 37th Street</p>  |  |   |   |
| <p>5. SEX</p> <p style="font-size: 18pt;">Female</p>  | <p>6. RACE</p> <p style="font-size: 18pt;">White</p> | <p>7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br/>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>  | <p>8. DATE OF BIRTH</p> <p style="font-size: 18pt;">10 June 1915</p> | <p>9. AGE (In years last birthday)</p> <p style="font-size: 18pt;">56</p>   | <p>If Under 1 Yr. Months Days<br/>If Under 24 Hrs. Hours Min.</p> |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</p> <p style="font-size: 18pt;">Clerical</p>   |  | <p>10B. KIND OF BUSINESS OR INDUSTRY</p> <p style="font-size: 18pt;">Bureau of Education</p>   |  | <p>11. BIRTHPLACE (State or foreign country)</p> <p style="font-size: 18pt;">Maryland</p>   |   |
| <p>12. CITIZEN OF WHAT COUNTRY?</p> <p style="font-size: 18pt;">USA</p>   |  | <p>13. FATHER'S NAME</p> <p style="font-size: 18pt;">Walter Herion</p>   |  | <p>14. MOTHER'S MAIDEN NAME</p> <p style="font-size: 18pt;">Anna Leutner</p>  |   |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p> <p style="font-size: 18pt;">No</p>  |  | <p>16. SOCIAL SECURITY NO.</p> <p style="font-size: 18pt;">215 07 0243</p>   |  | <p>17. INFORMANT</p> <p style="font-size: 18pt;">J. Marvin Peregoy</p>  |   |
| <p>18. ADDRESS</p> <p style="font-size: 18pt;">same</p>   |  |  |  |   |   |
| <p>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p style="font-size: 18pt;">Pulmonary metastases</p>  |  | <p>CAUSE OF DEATH</p> <p>(A) IMMEDIATE CAUSE<br/>DUE TO, OR AS A CONSEQUENCE OF:</p> <p style="font-size: 18pt;">Generalized metastases.</p>   |  | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p> <p style="font-size: 18pt;">2 hr.</p>   |   |
| <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p style="font-size: 18pt;">Generalized metastases.</p>   |  | <p>(B) DUE TO, OR AS A CONSEQUENCE OF:</p> <p style="font-size: 18pt;">Carcinoma of the Ovary</p>  |  | <p style="font-size: 18pt;">5 hr.</p>   |   |
| <p>(C) DUE TO, OR AS A CONSEQUENCE OF:</p> <p style="font-size: 18pt;">Carcinoma of the Ovary</p>   |  |  |  | <p style="font-size: 18pt;">1 year</p>  |   |
| <p style="text-align: center; font-weight: bold;">II</p>  |  |  |  |   |   |
| <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>   |  |  |  |   |   |
| <p>19A. DATE OF OPERATION</p> <p style="font-size: 18pt;">0</p>   |  | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p> <p style="font-size: 18pt;">—</p>  |  | <p>20A. AUTOPSY? (Yes or No)</p> <p style="font-size: 18pt;">—</p>  |   |
| <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> <p style="font-size: 18pt;">—</p>   |  |  |  |   |   |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p> <p style="font-size: 18pt;">—</p>  |  | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p> <p style="font-size: 18pt;">—</p>  |  | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p> <p style="font-size: 18pt;">—</p>   |   |
| <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p> <p style="font-size: 18pt;">—</p>  |  | <p>21E. INJURY OCCURRED</p> <p>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>   |  | <p>21F. HOW DID INJURY OCCUR?</p> <p style="font-size: 18pt;">—</p>   |   |
| <p>22. I certify that (I) (<del>this hospital</del>) attended the deceased from <span style="font-size: 18pt;">9-13</span> 19 <span style="font-size: 18pt;">71</span> to <span style="font-size: 18pt;">Present</span> 19 <span style="font-size: 18pt;">—</span>, that (I) <del>last</del> saw the deceased alive on <span style="font-size: 18pt;">1/17/72</span> 19 <span style="font-size: 18pt;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> |  |  |  |   |   |
| <p>23A. SIGNATURE</p> <p style="font-size: 18pt;">George J. Richards Jr. M.D.</p>   |  | <p>23B. DATE SIGNED</p> <p style="font-size: 18pt;">1/27/72</p>  |  | <p>23C. PHYSICIAN'S NAME (Type)</p> <p style="font-size: 18pt;">George J. Richards Jr. M.D.</p>   |   |
| <p>23D. ADDRESS</p> <p style="font-size: 18pt;">6701 N. CHARLES ST 21204</p>  |  |  |  |   |   |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)</p> <p style="font-size: 18pt;">Burial</p>  |  | <p>24B. DATE</p> <p style="font-size: 18pt;">29 Jan 72</p>   |  | <p>24C. NAME OF CEMETERY OR CREMATORY</p> <p style="font-size: 18pt;">Loudon Park Cemetery</p>  |   |
| <p>24D. LOCATION (City, town, or county) (State)</p> <p style="font-size: 18pt;">Baltimore Maryland</p>   |  |  |  |   |   |
| <p>25A. DATE REC'D BY HEALTH DEPT.</p> <p style="font-size: 18pt;">JAN 28 1972</p>  |  | <p>25B. NAME OF REGISTRAR</p> <p style="font-size: 18pt;">Robert E. Taylor M.D.</p>  |  | <p>25C. FUNERAL DIRECTOR</p> <p style="font-size: 18pt;">Burgess Funeral Home, Baltimore Maryland</p>   |   |
| <p>25D. ADDRESS</p> <p style="font-size: 18pt;">Walter J. Henss</p>   |  |  |  |   |   |





This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

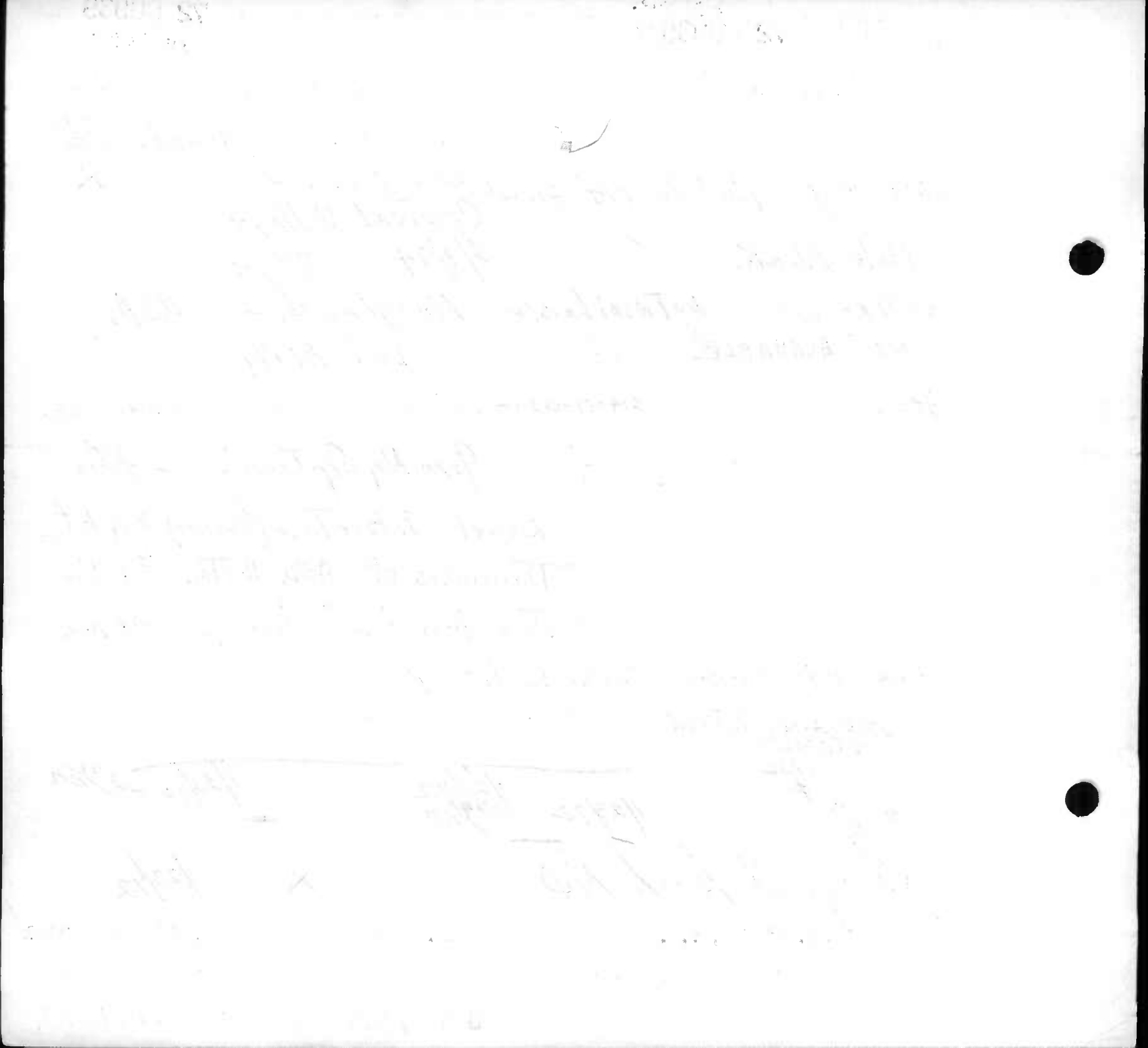
|  |              |  |                             |   |   |                                     |  |
|--|--------------|--|-----------------------------|---|---|-------------------------------------|--|
| D-000  |              | 72 00938   |                             | BALTIMORE CITY HEALTH DEPARTMENT  |   | 72 00938                            |  |
| BIRTH NO.  |              |  |                             | CERTIFICATE OF DEATH  |   | REG. NO.                            |  |
| 1. NAME OF DECEASED<br>(Type or Print)<br>Ella DAY   |              |  |                             | 2. DATE AND HOUR OF DEATH<br>January 22, 1972 11:30 A.M.  |   |                                     |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>90 Midtown Home, Inc.<br>808 St. Paul Street<br>Baltimore, Maryland   |              |  |                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Maryland<br>B. COUNTY 1803<br>C. CITY OR TOWN Baltimore<br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER 919 W. Baltimore Street |   |                                     |  |
| 5. SEX<br>F  | 6. RACE<br>C | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>9/17/83 | 9. AGE (in years last birthday) 88  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |                                     |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Housewife   |              | 10B. KIND OF BUSINESS OR INDUSTRY<br>Home  |                             | 11. BIRTHPLACE (State or foreign country)<br>Penna  |   | 12. CITIZEN OF WHAT COUNTRY?<br>USA |  |
| 13. FATHER'S NAME<br>? Boyer   |              |  |                             | 14. MOTHER'S MAIDEN NAME<br>Unknown   |   |                                     |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No   |              | 16. SOCIAL SECURITY NO.<br>710-09-6853   |                             | 17. INFORMANT ADDRESS<br>Mr. Glenn Day Baltimore, Md. 21230   |   |                                     |  |
| 18. CAUSE OF DEATH<br>I<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>19A. DATE OF OPERATION<br>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>20A. AUTOPSY? (Yes or No) No<br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)<br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br>21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR?<br>22. I certify that (I) (this hospital) attended the deceased from December 8 19 71 to January 22 19 72 that (I) (we) last saw the deceased alive on January 22 19 72 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.<br>23A. SIGNATURE<br>23B. DATE SIGNED 1-22-72<br>23C. PHYSICIAN'S NAME (Type)<br>23D. ADDRESS<br>24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial<br>24B. DATE<br>1-25-72<br>24C. NAME OF CEMETERY OR CREMATORY<br>Springfield Cemetery<br>24D. LOCATION (City, town, or county) (State)<br>Sykesville, Md.<br>25A. DATE REC'D BY HEALTH DEPT.<br>JAN 28 1972<br>25B. NAME OF REGISTRAR<br>Robert E. Taylor<br>25C. FUNERAL DIRECTOR<br>Harry L. Haight<br>ADDRESS<br>Sykesville, Md. |              |  |                             |   |   |                                     |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

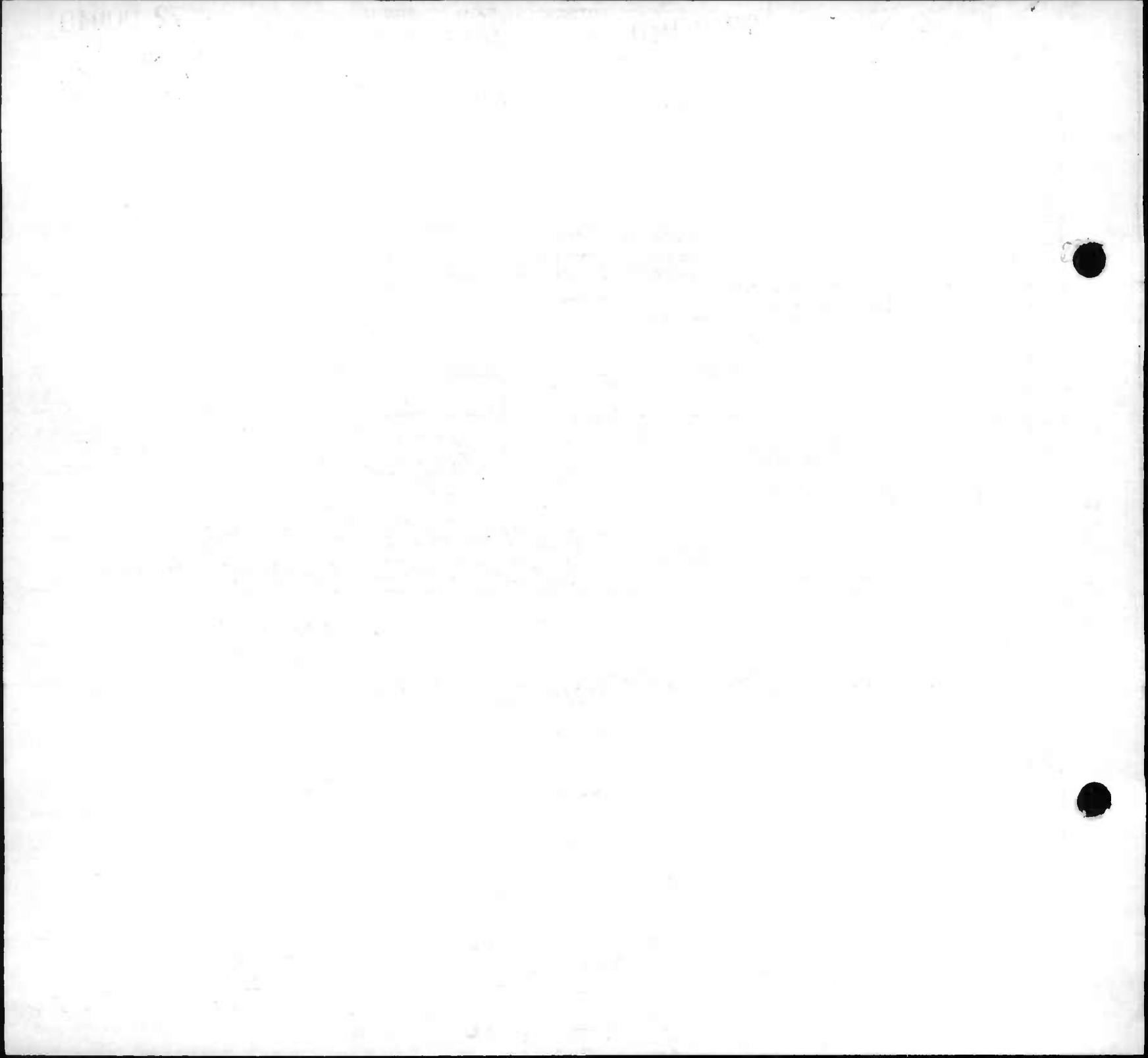
|   |                      |   |                                |  |
|---|----------------------|---|--------------------------------|--|
| B-320 72 00939  |                      | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |                                | 72 00939<br>REG. NO.   |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Julius Boots</u>  |                      | 2. DATE AND HOUR OF DEATH<br><u>2:25 P.M. 1/23/72</u> <u>2:25 P.M.</u> M.   |                                |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>UNIV. Hosp. Bal To. Md 21201</u>  |                      | 4. USUAL RESIDENCE (Where deceased lived, if (institute) had residence before admission)<br>A. STATE <u>Md.</u> B. COUNTY <u>PRINCE Frederick, Md.</u><br>C. CITY OR TOWN <u>Prince Frederick</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <u>CENTRAL Village</u> <u>5400</u> |                                |  |
| 5. SEX <u>Male</u>  | 6. RACE <u>Black</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>2/9/94</u> | 9. AGE (In years last birthday) <u>77 yrs.</u>                           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Labor</u>  |                      | 10B. KIND OF BUSINESS OR INDUSTRY <u>NOT AVAILABLE</u>  |                                | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u>                |
| 13. FATHER'S NAME <u>NOT AVAILABLE</u> <u>Jeremiah Boots</u>  |                      | 14. MOTHER'S MARRIED NAME <u>Sarah E. Howe</u> <u>NOT APPLY</u>   |                                |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>YES</u> <u>WW1</u>  |                      | 16. SOCIAL SECURITY NO. <u>214-01-0248</u>  |                                | 17. INFORMANT <u>Pauline Jones Prince Frederick, Md.</u> ADDRESS         |
| 18. <u>441.2.1</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION first.  |                      | (A) IMMEDIATE CAUSE <u>Gram. Neg. Septicemia</u> - <u>plus</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) <u>Bowel Intarection (Massive)</u> <u>≈ 4 1/2 hrs.</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) <u>Thrombosis of ABD. Aorta</u> <u>≈ 6 hrs</u>  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>Rupture ABD. Aortic Aneurysm</u>   |                      | <u>48 hrs</u>   |                                |  |
| 19A. DATE OF OPERATION <u>1/21/72</u>   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Bowel Aneurysm of Aorta + PERITONITIS</u>   |                                | 20A. AUTOPSY (Yes or No) <u>YES</u>                                      |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If medical examiner notified) <u>MED. EXAM. Notified</u>   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (Approx.) <u>1/23/72</u> <u>2:25 P.M.</u>   |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input checked="" type="checkbox"/>   |                                | 21F. HOW DID INJURY OCCUR?   |
| 22. I certify that (1) (this hospital) attended the deceased from <u>1/21/72</u> 19__ to <u>1/23/72</u> 19__ that (we) last saw the deceased alive on <u>1/23/72</u> <u>2:25 P.M.</u> and that in (my) <u>medical</u> opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |   |                                |  |
| 23A. SIGNATURE <u>George M. Wricko, M.D.</u>  |                      | 23B. DATE SIGNED <u>1/23/72</u>   |                                | 23C. PHYSICIAN'S NAME (Type) <u>GEORGE M. WRICKO, M.D.</u>               |
| 24A. BURIAL, CREMATION, REMOVAL (Specify) <u>1-28-72</u>  |                      | 24B. NAME OF CEMETERY OR CREMATORY <u>Brown's Church Cem.</u>   |                                | 24C. LOCATION (City, town, or county) (State) <u>Calvert Co. Md.</u>     |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1972</u>  |                      | 25B. NAME OF REGISTRAR <u>Paul E. J. Ewell</u>  |                                | 25C. FUNERAL DIRECTOR <u>Prince Frederick</u>                            |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

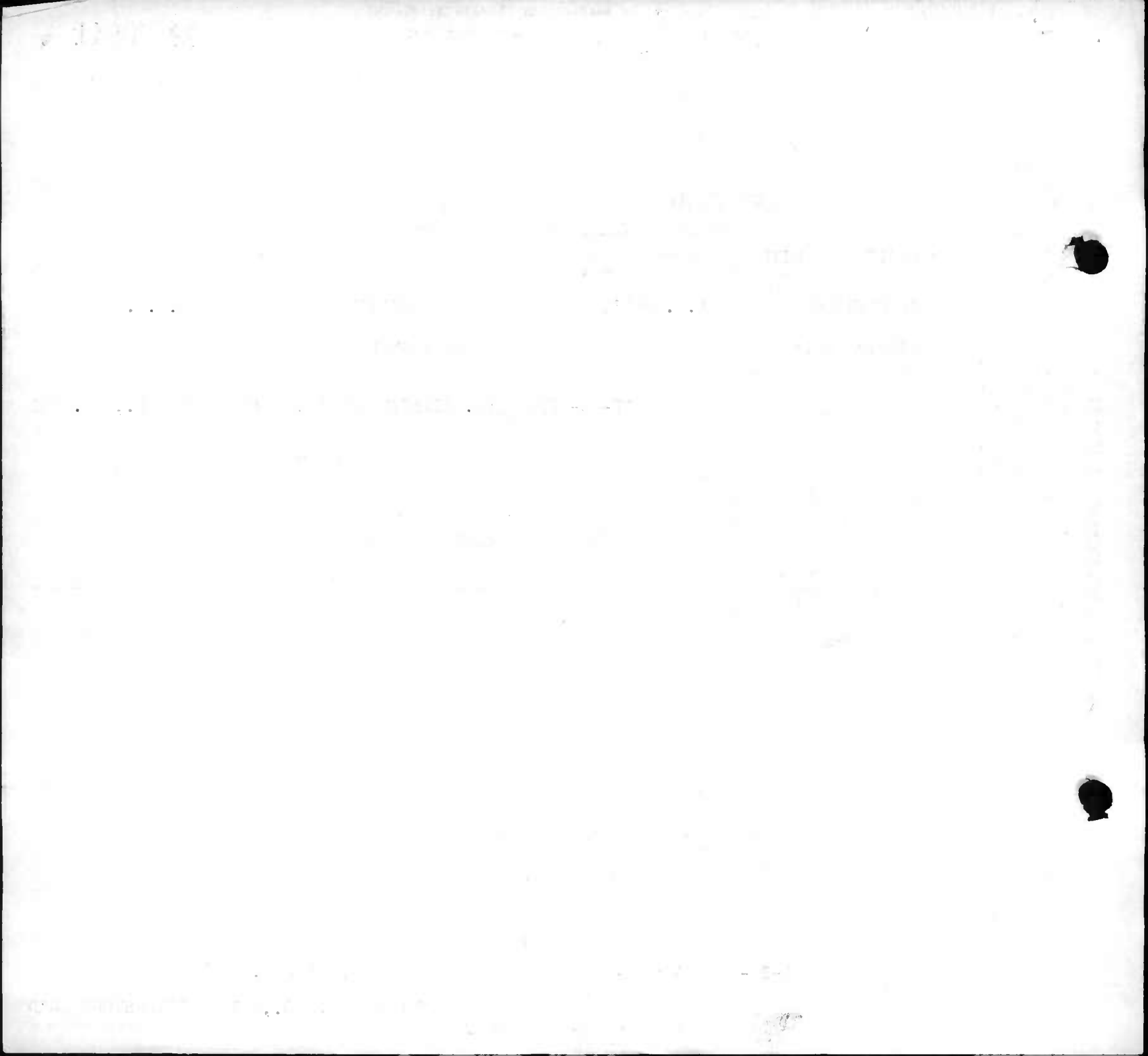
| Baltimore City Health Department   |                             |   |                                    | REG. NO. 72 00840  |  |
|--|-----------------------------|---|------------------------------------|--|--|
| 4-325  |                             | 72 00940  |                                    | CERTIFICATE OF DEATH   |  |
| BIRTH NO.  |                             | 1. NAME OF DECEASED<br>(Type or Print) <u>Alice A. Hutchins</u>   |                                    | 2. DATE AND HOUR OF DEATH<br><u>1/25/72</u> <u>7</u> <u>1</u> <u>415</u> A.M.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                             | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>MD</u> B. COUNTY <u>PG</u>   |                                    | C. CITY OR TOWN <u>Agawam</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Maryland General Hospital</u><br><u>48</u>  |                             | IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION  |                                    | E. STREET AND NUMBER <u>Rt. 1</u> Box <u>100A</u>  |  |
| 5. SEX<br><u>Female</u>  | 6. RACE<br><u>Caucasian</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH<br><u>9-31-89</u> | 9. AGE (in years last birthday)<br><u>82</u>   | 10. CITIZEN OF WHAT COUNTRY?<br><u>United States</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Homemaker</u>  |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>—</u>   |                                    | 11. BIRTHPLACE (State or foreign country)<br><u>MD</u>   |  |
| 13. FATHER'S NAME<br><u>?</u>  |                             | 14. MOTHER'S MAIDEN NAME<br><u>?</u>  |                                    | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>    |  |
| 16. SOCIAL SECURITY NO.<br><u>280-44-7189</u>  |                             | 17. INFORMANT<br><u>Son</u>   |                                    | ADDRESS<br><u>Roland Ave Md</u>  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><u>Pulmonary Emphysema</u>   |                             | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br><u>Cholelithiasis</u><br>(B) DUE TO OR AS A CONSEQUENCE OF:<br><u>POSSIBLE CHOLELITHIASIS</u><br>(C) DUE TO OR AS A CONSEQUENCE OF:<br><u>POST-OP CHOLELITHIASIS</u> |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>16 Hrs</u>  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                             | OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><u>Fatty metamorphosis of liver</u>                                       |                                    |  |  |
| 19A. DATE OF OPERATION<br><u>1/22/71</u>   |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>Recurrent cholelithiasis</u>   |                                    | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                    | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/9</u> 19 <u>72</u> to <u>1/25</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/25</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death. |                             | 23A. SIGNATURE<br><u>Lo Hine MD</u>   |                                    | 23B. DATE SIGNED<br><u>1/25/72</u>   |  |
| 23C. PHYSICIAN'S NAME (Type)   |                             | 23D. ADDRESS  |                                    | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  |
| 24B. DATE<br><u>1/27/72</u>  |                             | 24C. NAME OF CEMETERY OR CREMATORY<br><u>Woodlawn</u>   |                                    | 24D. LOCATION (City, town, or county) (State)<br><u>Baltimore Md</u>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>JAN 28 1972</u>  |                             | 25B. NAME OF REGISTRAR<br><u>Paul E. Chermant</u>   |                                    | 25C. FUNERAL DIRECTOR<br><u>3617 Chestnut Ave.</u>   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |
|---|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <b>72 00941</b>   |  |
| BIRTH NO. <b>G-430</b>  |  | 72 00941 CERTIFICATE OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>PEARL GOLD</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>1/23/72 4:20 P.M.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>MARYLAND GENERAL HOSPITAL</b>   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY <b>2831</b> |  |
| 5. SEX <b>FEMALE</b>  |  | 6. RACE <b>WHITE</b>   |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>8-10-06</b>  |  |
| 9. AGE (in years last birthday) <b>65</b>   |  | 10. UNDER 1 Yr. Months Days  |  |
| 11. UNDER 24 Hrs. Hours Min.  |  | 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>ACCOUNTING</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>U.S. GOV'T</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>MD. BALTIMORE</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  |
| 13. FATHER'S NAME<br><b>WILLIAM GOLD</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>ANNA SHUL</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.<br><b>577-03-0382</b>  |  |
| 17. INFORMANT<br><b>MRS. LILLIAN LIPMAN, 6611 EBERLE DR. APT. 202</b>   |  | ADDRESS  |  |
| 18. <b>198.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>SQUAMOUS CARCINOMA</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>w/ Metastasis to orbit &amp; brain</b> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |
| 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  | 21D. TIME OF INJURY (APPROX.)  |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1-17</b> 19 <b>72</b> to <b>1-23</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1-23</b> 19 <b>72</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |  |  |
| 23A. SIGNATURE<br><b>Beltran M.D.</b>   |  | 23B. DATE SIGNED<br><b>1/23/72</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>JUAN A. BELTRAN M.D.</b>   |  | 23D. ADDRESS<br><b>MARYLAND GENERAL HOSPITAL</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |  | 24B. DATE<br><b>1-25-72</b>  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><b>ANSHE EMUNAH</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>BALTIMORE, MARYLAND</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1972</b>   |  | 25B. NAME OF REGISTRAR<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>  |  |
| 25C. FUNERAL DIRECTOR   |  | ADDRESS  |  |





72 00942

BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00942

BIRTH NO.

|  |  |   |  |
|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>JOSEPH FELDMAN</b>  |  | 2. DATE OF DEATH<br>Known <input type="checkbox"/> Month Day Year<br>Estimated <input type="checkbox"/> Hour M.         |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(If NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>42 Sinai Hospital</b>   |  | 3. DATE PRONOUNCED DEAD<br>Month Day Year Hour M.<br><b>1 24 1972 8:17 a</b>  |  |
| 6. SEX<br><b>male</b>  |  | 7. RACE<br><b>white</b>   |  |
| 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | C. CITY OR TOWN<br><b>Philadelphia</b>  |  |
| 9. DATE OF BIRTH<br><b>OCTOBER 20, 1922</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                           |  |
| 10. AGE (In years last birthday)<br><b>49</b>  |  | E. STREET AND NUMBER<br><b>8219 Williams St. AVENUE</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>DARBY, PENNSYLVANIA</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>VICTOR FELDMAN</b>   |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>SHOES</b>              |  |
| 15. MOTHER'S MAIDEN NAME<br><b>BERTHA ?</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?<br>(Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b> |  |
| 17. SOCIAL SECURITY NO.  |  | 18. INFORMANT<br><b>GOLDSTEIN FUNERAL HOME, PHILADELPHIA, PA. 19126</b>   |  |
| 19. <b>412.4</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Arteriosclerotic cardiovascular disease</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |  |
| 20A. DATE OF OPERATION<br><b>0</b>   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 21. AUTOPSY? (Yes or No)<br><b>no</b>  |  |   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                |  |
| 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR?   |  |   |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>               |  |
| 22F. HOW DID INJURY OCCUR?   |  |   |  |
| 23.<br>I certify that I held on Inquiry <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Russell S. Fisher, M.D.</b> M.D.<br>EXAMINER'S NAME (Type)<br>DATE SIGNED <b>1-24-72</b> |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>REMOVAL- BURIAL</b>   |  | 24B. DATE<br><b>1-26-72</b>   |  |
| 24C. NAME of CEMETERY or CREMATORY<br><b>MONTIFIORE</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>FOXCHASE, MONTG. CO., PENNSYLVANIA</b>                              |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1972</b>  |  | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher, M.D.</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>   |  | ADDRESS   |  |

35 10015

35 10015

EXHIBIT 100-10015

EXHIBIT 100-10015

EXHIBIT 100-10015

EXHIBIT 100-10015

EXHIBIT 100-10015

EXHIBIT 100-10015

EXHIBIT 100-10015

EXHIBIT 100-10015

EXHIBIT 100-10015

EXHIBIT 100-10015

EXHIBIT 100-10015

EXHIBIT 100-10015

EXHIBIT 100-10015

EXHIBIT 100-10015

EXHIBIT 100-10015

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |   |  |
|---|--|--|--|---|--|
| BIRTH NO.   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO.  |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |  | 72 00943   |  | 72 00943  |  |
| DOROTHY AGNES REED  |  | 2. DATE AND HOUR OF DEATH  |  | January 25, 72  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)                                  |  | A. STATE<br>Maryland  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>39 Provident Hospital   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | B. COUNTY<br>1537   |  |
| 5. SEX<br>Female  |  | 6. RACE<br>Colored   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH<br>April 12, 1919  |  | 9. AGE (In years last birthday)<br>52  |  | 10. If Under 1 Yr. Months: Days: Hours: Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Receptionist   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)<br>Baltimore, Maryland  |  |
| 13. FATHER'S NAME<br>Daniel A. Dixon, Sr.   |  | 14. MOTHER'S MAIDEN NAME<br>Lillian C. Richardson  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>No  |  | 16. SOCIAL SECURITY NO.<br>218-18-9828   |  | 17. INFORMANT<br>George H. Dixon, 2245 Penrose Ave.   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc., but the disease, injury or complication which caused death.)<br>Hypertensive cardiovascular disease<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |  | 19A. DATE OF OPERATION<br>0  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>              |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 5-28-1970 to Jan 7, 1972 that (I) (we) last saw the deceased alive on 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |  |  |   |  |
| 23A. SIGNATURE<br>JURGET JEDDY, MD  |  | 23B. DATE SIGNED<br>1-27-72  |  | 23C. PHYSICIAN'S NAME (Type)<br>JURGET JEDDY, MD  |  |
| 23D. ADDRESS<br>542 N. FULTON AVE   |  | 23E. DEGREE<br>DEGREE  |  | 23F. ADDRESS<br>542 N. FULTON AVE   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |  | 24B. DATE<br>1/28/72   |  | 24C. NAME of CEMETERY or CREMATORY<br>Baltimore, National   |  |
| 24D. LOCATION<br>Baltimore, Maryland  |  | 24E. DATE REC'D BY HEALTH DEPT.<br>JAN 28 1972   |  | 24F. NAME OF REGISTRAR<br>Robert E. J. J. J.  |  |
| 24G. FUNERAL DIRECTOR<br>Kenneth Law  |  | 24H. ADDRESS<br>4611 Park Heights Ave.   |  | 24I. DATE<br>JAN 28 1972  |  |

III

...

...

...

...

...

...

...

...

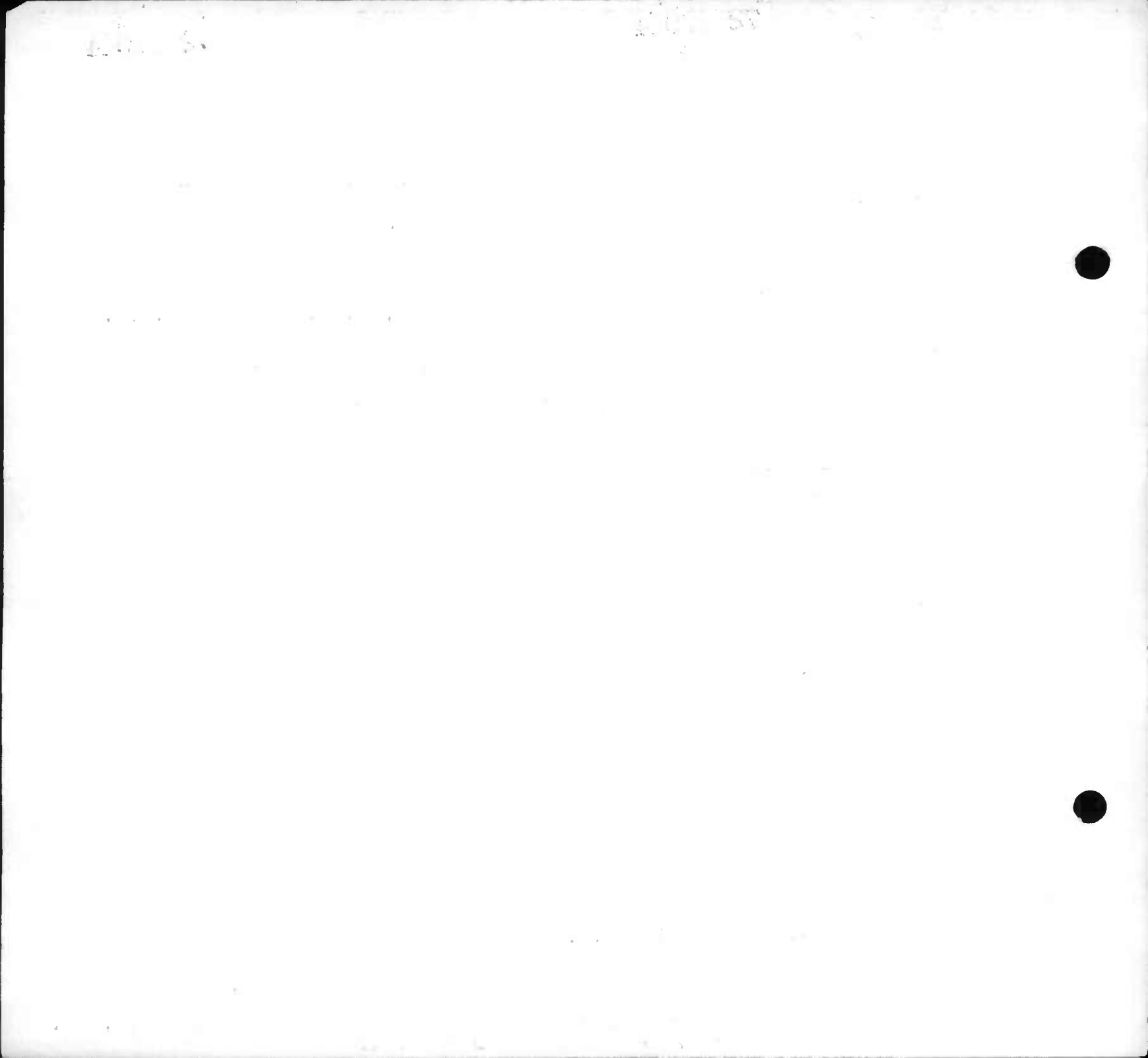
...

...

...

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |   |  |   |  |
|---|--|--|--|---|--|---|--|
| BIRTH NO. <u>5540</u>   |  | 72 00944   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <u>72 00944</u>  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Samuel Plumia</u>   |  |  |  | 2. DATE AND HOUR OF DEATH<br><u>1/23/72</u> <u>1/2 20 P</u> M.  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>33 JOHNS HOPKINS HOSPITAL</u>   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <u>MARYLAND</u><br>B. COUNTY <u>302</u>  |  |   |  |
| 5. SEX<br><u>FEMALE</u>   |  | 6. RACE<br><u>NEGRO</u>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                                       |  | 8. DATE OF BIRTH<br><u>05/12/13</u>   |  |
| 9. AGE (In years last birthday)<br><u>58</u>  |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>MACHINIST</u> |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>BAG FACTORY</u>   |  | 11. BIRTHPLACE (State or foreign country)<br><u>MANNING, S. C.</u>                |  |
| 13. FATHER'S NAME<br><u>SAMUEL ELMOR</u>  |  |  |  | 14. MOTHER'S MAIDEN NAME<br><u>CHRISTINE BROGDAN</u>  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>   |  |  |  | 16. SOCIAL SECURITY NO.<br><u>2-109</u>   |  | 17. INFORMANT ADDRESS<br><u>MILDRED WIGGINS 1117 LYNDBURST STREET</u>             |  |
| 18. <u>431.01</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  |  |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <u>L. post coron artery</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <u>Cerebral Anemia</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <u>HYPER TENSION</u> |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |   |  |   |  |
| 19A. DATE OF OPERATION<br><u>3/12/72</u>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><u>pericardiotomy</u>                                      |  | 20A. AUTOPSY? (Yes or No)<br><u>Yes</u>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><u>no</u> |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                       |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (APPROX.)   |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>      |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/20</u> 19 <u>72</u> to <u>1/23</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1/23</u> 19 <u>72</u> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.     |  |  |  |   |  |   |  |
| 23A. SIGNATURE<br><u>Melvin H. Epstein</u>  |  |  |  | 23B. DATE SIGNED<br><u>1/23/72</u>  |  | 23C. PHYSICIAN'S NAME (Type)<br><u>EPSTEIN, MELVIN M.D.</u>                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  | 24B. DATE<br><u>1/27/72</u>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>WOODLAND</u>   |  | 24D. LOCATION (City, town, or county) (State)<br><u>RICHMOND, VIRGINIA</u>        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>JAN 28 1972</u>   |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Taylor</u>  |  | 25C. FUNERAL DIRECTOR<br><u>CHILES' FUNERAL HOME</u>  |  | 25D. ADDRESS<br><u>RICHMOND, VA. 23223</u>  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| B-634  |                        | BALTIMORE CITY HEALTH DEPARTMENT  |                                   | X   |  | 72 00945   |  |
|--|------------------------|---|-----------------------------------|---|--|--|--|
| BIRTH NO.  |                        | 72 00945  |                                   | CERTIFICATE OF DEATH  |  | REG. NO.   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>MARGARET G. BOERTLEIN</b>  |                        |   |                                   | 2. DATE AND HOUR OF DEATH<br><b>1/22/72 852 P.M.</b>  |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>UNIV OF MARYLAND HOSPITAL 38</b>   |                        |   |                                   | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>PRINCE GEORGE</b><br>C. CITY OR TOWN <b>SEAT Pleasant</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>190 73rd ST.</b> |  |  |  |
| 5. SEX<br><b>F</b>   | 6. RACE<br><b>CAUC</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/2/04</b> | 9. AGE (in years last birthday) <b>67</b>   | If Under 1 Yr. Months: Days: Hours: Min. | If Under 24 Hrs. Hours: Min.                                       |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>institutionalized patient</b>  |                        |   |                                   | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>GERMANY</b>        |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |                        |   |                                   | 13. FATHER'S NAME<br><b>CHRISTOPHER BOERTLEIN</b>   |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>unknown</b>   |                        |   |                                   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  |  |  |
| 16. SOCIAL SECURITY NO.<br><b>unknown</b>  |                        |   |                                   | 17. INFORMANT<br><b>JOHN BOERTLEIN 2549 Oak Glen Way, Md.</b>   |  |  |  |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>CARDIAC ARREST</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>19A. DATE OF OPERATION <b>1/13/72</b> 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PERFORATED GASTRIC CANCER</b><br>20A. AUTOPSY? (Yes or No) <b>NO</b> 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br>21A. ACCIDENT WAS UNDERLYING CAUSE OF DEATH (Indify medical examined) <b>NO</b> 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)<br>21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)<br>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br>21F. HOW DID INJURY OCCUR? |                        |   |                                   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>IMMEDIATE</b><br><b>UNKNOWN</b>  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1/13 1972</b> to <b>1/22 1972</b> that (I) (we) last saw the deceased alive on <b>1/22 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                        |   |                                   |   |  |  |  |
| 23A. SIGNATURE<br><b>Patrick A. Coyne MD</b>   |                        |   |                                   | 23B. DATE SIGNED<br><b>1/22/72</b>  |  | 23C. PHYSICIAN'S NAME (Type)<br><b>PATRICK A. COYNE</b>            |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                        |   |                                   | 24B. DATE<br><b>1-26-1972</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Fort Lincoln Cemetery</b> |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Bladensburg, Maryland</b>  |                        |   |                                   | 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1972</b>   |  |  |  |
| 25B. NAME OF REGISTRAR<br><b>Simmons Bros</b>  |                        |   |                                   | 25C. FUNERAL DIRECTOR<br><b>Simmons Bros 1661-Good Hope Rd SE Wash. DC</b>  |  |  |  |

7100 87

7100 87

12



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |         |  |                  |   |                           |   |                           |
|---|---------|--|------------------|---|---------------------------|---|---------------------------|
| W-425   |         | 72 00946   |                  | BALTIMORE CITY HEALTH DEPARTMENT  |                           | 72 00946  |                           |
| BIRTH NO.   |         | 1. NAME OF DECEASED<br>(Type or Print)   |                  | 2. DATE AND HOUR OF DEATH   |                           | REG. NO.  |                           |
|   |         | MABEL WILSON   |                  | 1-25-72 11:33 AM  |                           |   |                           |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |         |  |                  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission) |                           |   |                           |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |         |  |                  | A. STATE B. COUNTY  |                           |   |                           |
| THE JOHNS HOPKINS HOSPITAL  |         |  |                  | MARYLAND  |                           |   |                           |
| 33  |         |  |                  | C. CITY OR TOWN   |                           | D. INSIDE CITY LIMITS?  |                           |
|   |         |  |                  | BALTIMORE   |                           | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                           |
|   |         |  |                  | E. STREET AND NUMBER  |                           |   |                           |
|   |         |  |                  | 524 N. CALHOUN ST.  |                           |   |                           |
| 5. SEX  | 6. RACE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>    | 8. DATE OF BIRTH | 9. AGE (in years last birthday)   | 10. If Under 1 Yr. Months | 11. If Under 24 Hrs. Days   | 12. If Under 24 Hrs. Min. |
| FEMALE  | NEGRO   | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                       | 8-16-28          | 43  |                           |   |                           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |         | 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country)   |                           | 12. CITIZEN OF WHAT COUNTRY?  |                           |
| waitress  |         |  |                  | N.C.  |                           | U.S.A.  |                           |
| 13. FATHER'S NAME   |         |  |                  | 14. MOTHER'S MAIDEN NAME  |                           |   |                           |
| JOSEPH EVANS  |         |  |                  | TERRY HANKINS   |                           |   |                           |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) [If yes, give war or dates of service]  |         | 16. SOCIAL SECURITY NO.  |                  | 17. INFORMANT ADDRESS   |                           |   |                           |
| no  |         |  |                  | Loretta Wilson 518 Calhoun St.  |                           |   |                           |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |         |  |                  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |                           |   |                           |
| 303.21  |         |  |                  | 30 min  |                           |   |                           |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |         |  |                  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |                           |   |                           |
| ANTECEDENT CAUSES   |         |  |                  | Cardiorespiratory Arrest  |                           |   |                           |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |         |  |                  | (B) Possible severe c asphyxia  |                           |   |                           |
|   |         |  |                  | (C) Chronic alcoholism  |                           |   |                           |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |         |  |                  |   |                           |   |                           |
| 19A. DATE OF OPERATION  |         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  | 20A. AUTOPSY? (Yes or No)   |                           | 20B. IF YES, WERE FINDINGS CONSIDERED IN CIFYING CAUSES OF DEATH?   |                           |
| 0   |         |  |                  |   |                           |   |                           |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |                  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |                           |   |                           |
| No  |         |  |                  |   |                           |   |                           |
| 21D. TIME OF INJURY (APPROX.)   |         | 21E. INJURY OCCURRED   |                  | 21F. HOW DID INJURY OCCUR?  |                           |   |                           |
|   |         | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |                  |   |                           |   |                           |
| 22. I certify that (I) (this hospital) attended the deceased from 1/25 1972 to 1/25 1972 that (I) (we) last saw the deceased alive on 1/25 1972 and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |         |  |                  |   |                           |   |                           |
| 23A. SIGNATURE  |         |  |                  | 23B. DATE SIGNED  |                           |   |                           |
| GREGORY B. BUCKLEY MD   |         |  |                  |   |                           |   |                           |
| 23C. PHYSICIAN'S NAME (Type)  |         | 23D. ADDRESS   |                  |   |                           |   |                           |
| GREGORY B. BUCKLEY MD   |         | Johns Hopkins Hospital   |                  |   |                           |   |                           |
| 24A. BURIAL REMOVAL (Specify)   |         | 24B. DATE  |                  | 24C. NAME of CEMETERY or CREMATORY  |                           | 24D. LOCATION (City, town, or county) (State)                       |                           |
| Burial  |         | 1-30-72  |                  | Church Cemetery   |                           | Wilmington, N.C.  |                           |
| 25A. DATE REC'D BY HEALTH DEPT.   |         | 25B. NAME OF REGISTRAR   |                  | 25C. FUNERAL DIRECTOR   |                           | ADDRESS   |                           |
| JAN 28 1972   |         | V. Bailey  |                  | Kelson F. H.  |                           | 1348 Calhoun Street   |                           |

15 1968

15 1968

15 1968

15 1968

15 1968

15 1968

15 1968

15 1968

15 1968

15 1968

15 1968

15 1968

15 1968

15 1968

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                         |   |  |   |  |  |  |
|--|-------------------------|---|--|---|--|--|--|
| S-314  |                         | 72 00947  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 72 00947  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>JOSEPHINE STAPLES</b>  |                         |   |  | 2. DATE AND HOUR OF DEATH<br><b>1-24-72</b> <b>655</b> P.M.   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>SINAI HOSPITAL OF BALTIMORE</b><br><b>42</b>   |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2719</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>5729 Clover Rd.</b> |  |  |  |
| 5. SEX<br><b>FEMALE</b>  | 6. RACE<br><b>BLACK</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>8-15-00</b>  | 9. AGE (In years last birthday)<br><b>71</b> | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                         |   |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)<br><b>N.C.</b>                                   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |                         |   |  | 13. FATHER'S NAME<br><b>Jasper Caldwell</b>   |  |  |  |
| 14. MOTHER'S MAIDEN NAME<br><b>72 00948</b>  |                         |   |  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |  |  |  |
| 16. SOCIAL SECURITY NO.  |                         |   |  | 17. INFORMANT (daug)<br><b>Mildred Givens</b> ADDRESS <b>same</b>   |  |  |  |
| 18. <b>450X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE <b>CARDIO-PULMONARY ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>PROBABLE</b><br>(B) <b>MULTIPLE PULMONARY EMBOLUS</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |                         |   |  |   |  |  |  |
| 19A. DATE OF OPERATION   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                       |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED While At <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1-18-72</b> 19 <b>72</b> to <b>1-24</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1-24</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |   |  |   |  |  |  |
| 23A. SIGNATURE<br><b>Susan Macth Cohen MD</b>  |                         |   |  | 23B. DATE SIGNED<br><b>1-24-72</b>  |  | 23C. PHYSICIAN'S NAME (Type)<br><b>DEGREE</b>  |  |
| 23D. ADDRESS<br><b>DEGREE</b>  |                         |   |  | 23E. ADDRESS  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |                         | 24B. DATE<br><b>1-29-72</b>   |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Mt. Auburn Cem.</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto., Md.</b>                        |  |
| 25A. DATE RECD BY HEALTH DEPT.<br><b>JAN 28 1972</b>   |                         | 25B. NAME OF REGISTRAR<br><b>John E. Gabe, M.D.</b>   |  | 25C. FUNERAL DIRECTOR<br><b>V. Bailey</b>   |  | ADDRESS<br><b>Kolson 4. H. 1348 Calhoun Street</b>   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| G-200   |                         | 72 00948  |                                     | BALTIMORE CITY HEALTH DEPARTMENT  |                               | 72 00948  |  |
|---|-------------------------|---|-------------------------------------|---|-------------------------------|---|--|
| BIRTH NO.   |                         |   |                                     | CERTIFICATE OF DEATH  |                               |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>GOUGH, JAMES</b>  |                         |   |                                     | 2. DATE AND HOUR OF DEATH<br><b>1/26/1972 2:00 A.M.</b>   |                               |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>LUTHERAN HOSPITAL OF MD.</b>   |                         |   |                                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY <b>1501</b> |                               |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><b>LUTHERAN HOSPITAL OF MD.</b>  |                         |   |                                     | C. CITY OR TOWN<br><b>BALTIMORE</b>   |                               | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
| E. STREET AND NUMBER<br><b>1410 N. SCHOOL ST.</b>   |                         |   |                                     |   |                               |   |  |
| 5. SEX<br><b>MALE</b>   | 6. RACE<br><b>NEGRO</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10/24/02</b> | 9. AGE (In years last birthday)<br><b>69</b>  | 10. Under 1 Yr. Months: Days: | 11. Under 24 Hrs. Hours: Min.   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                         | 10B. KIND OF BUSINESS OR INDUSTRY   |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |                               | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>Joseph Gough</b>  |                         |   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Anna Briscoe</b>   |                               |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                         | 16. SOCIAL SECURITY NO.   |                                     | 17. INFORMANT<br><b>Katherine Jackson 2430 7th St. Apt. 13</b>  |                               |   |  |
| 18. <b>486X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>pneumonia</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Chronic Lung Disease</b><br>8 days           |                         |   |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 days</b>   |                               |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |   |                                     |   |                               |   |  |
| 19A. DATE OF OPERATION  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |                               | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                               |   |  |
| 21D. TIME OF INJURY (Approx.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                     | 21F. HOW DID INJURY OCCUR?  |                               |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1-18-1972</b> to <b>1-26-1972</b> that (I) (we) last saw the deceased alive on <b>1-26-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |                                     |   |                               |   |  |
| 23A. SIGNATURE<br><b>D. S. Karbhari</b>   |                         |   |                                     | 23B. DATE SIGNED  |                               |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>D. S. KARBHARI</b>   |                         |   |                                     | 23D. ADDRESS<br><b>Lutheran Hosp Balto MD 21216</b>   |                               |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>1-29-72</b>   |                                     | 24C. NAME OF CEMETERY or CREMATORY<br><b>New Cathedral Cem.</b>   |                               | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>                        |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1972</b>   |                         | 25B. NAME OF REGISTRAR<br><b>James E. Bailey</b>  |                                     | 25C. FUNERAL DIRECTOR<br><b>Kelson F. H.</b>  |                               | ADDRESS<br><b>1348 Calhoun Street</b>   |  |

21000 50

21 50

40 50

...



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |  |   |  |
|---|--|---|--|---|--|
| D-616 72 00949  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 72 00949   |  |
| BIRTH NO.   |  | 1. NAME OF DECEASED<br>(Type or Print) DRIVER MARTIN  |  | 2. DATE AND HOUR OF DEATH<br>1/27/72 - 7:15 AM.   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  | 4. USUAL RESIDENCE (Where deceased lived, If institution: residence before admission)<br>A. STATE B. COUNTY<br>MARYLAND |  | M.  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>(If not in hospital or institution, give street address or location)<br>Lutheran Hospital of Maryland<br>46   |  | C. CITY OR TOWN<br>BALTIMORE  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 5. SEX<br>M   |  | 6. RACE<br>N  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Retired  |  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 8. DATE OF BIRTH<br>10-31-96  |  |
| 13. FATHER'S NAME<br>BRADFORD DRIVER  |  | 14. MOTHER'S MAIDEN NAME<br>CORRIS  |  | 9. AGE (In years last birthday)<br>75   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>YES   |  | 16. SOCIAL SECURITY NO.<br>212-32-1468  |  | 11. BIRTHPLACE (State or foreign country)<br>VA.  |  |
| 18. 162-1 I   |  | CAUSE OF DEATH  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>CARDIAC ARREST  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (B) BRONCHOGENIC CARCINOMA<br>DUE TO, OR AS A CONSEQUENCE OF:   |  |   |  |
| (C)   |  |   |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |   |  |   |  |
| 19A. DATE OF OPERATION<br>1/19/72   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CA. Hypertensive 2 Thoracic H. Artery                               |  | 20A. AUTOPSY? (Yes or No)<br>Yes  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Indefinitely medical examined)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>               |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 1/21/72 19 to 1/27/72 19 that (I) (we) last saw the deceased alive on 1/27/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |   |  |   |  |
| 23A. SIGNATURE<br>Gardner   |  | 23B. DATE SIGNED<br>1-27-72   |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>                             |  |
| 23C. PHYSICIAN'S NAME (Type)<br>Dr. E. Sandow   |  | 23D. ADDRESS  |  | DEGREE  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL  |  | 24B. DATE<br>1/30/72  |  | 24C. NAME OF CEMETERY or CREMATORY<br>Shepherdville   |  |
| 24D. LOCATION<br>Bloumester, Va   |  | (City, town, or county)   |  | (State)   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>JAN 28 1972  |  | 25B. NAME OF REGISTRAR<br>J. E. Johnson   |  | 25C. FUNERAL DIRECTOR<br>J. E. Johnson  |  |
| 1304 Central Ave.   |  | ADDRESS   |  |   |  |

15. 10. 19

15. 10. 19

15. 10. 19

15. 10. 19



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                         |   |  | REG. NO. <span style="font-size: 1.2em;">72 00950</span>                           |  |
|--|-------------------------|---|--|--|--|
| <b>BIRTH NO.</b><br><span style="font-size: 1.5em;">W-425</span> <span style="font-size: 1.2em;">72 00950</span>   |                         | <b>CERTIFICATE OF DEATH</b>   |  |  |  |
| <b>1. NAME OF DECEASED</b><br><small>(Type or Print)</small><br>Wilson, Margaret   |                         |   | <b>2. DATE AND HOUR OF DEATH</b><br>1/24/72 <span style="float: right;">9:45 P.M.</span>   |  |  |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br><b>FULL NAME OF HOSPITAL OR INSTITUTION</b><br><span style="font-size: 1.5em;">39</span> <span style="margin-left: 20px;">(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</span><br>Provident Hospital Complex<br>2600 Liberty Heights Ave.<br>Baltimore, Maryland 21215 |                         |   | <b>4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)</b><br>A. STATE <span style="float: right;">1505</span><br>Maryland<br><b>C. CITY OR TOWN</b><br>Baltimore<br><b>D. INSIDE CITY LIMITS?</b><br>YES <input type="checkbox"/> NO <input type="checkbox"/><br><b>E. STREET AND NUMBER</b><br>2326 Anoka Ave. |  |  |
| <b>5. SEX</b><br>Female  | <b>6. RACE</b><br>Black | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> | <b>8. DATE OF BIRTH</b><br>6/27/1902   |  | <b>9. AGE (In years last birthday)</b><br>69 |
| <b>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)</b><br>MA. (Housewife)  |                         |   | <b>11. BIRTHPLACE (State or foreign country)</b><br>South Carolina Greenville U. S.A.  |  |  |
| <b>13. FATHER'S NAME</b><br>Frank Willis   |                         |   | <b>14. MOTHER'S MAIDEN NAME</b><br>Elsie Willis  |  |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces (Yes, no or unknown) (If yes, give war or dates of service)</b><br>No.  |                         |   | <b>16. SOCIAL SECURITY NO.</b><br>_____  |  |  |
| <b>17. INFORMANT</b><br>Mrs. Louise Carlyle  |                         |   | <b>ADDRESS</b><br>2326 Anoka Avenue  |  |  |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br><small>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</small><br>412.3 I<br>ASHD  |                         |   | <b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____   |  |  |
| <b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         |   | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br>_____   |  |  |
| II   |                         |   |  |  |  |
| <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b>  |                         |   |  |  |  |
| <b>19A. DATE OF OPERATION</b><br>_____   |                         | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b><br>_____  |  | <b>20A. AUTOPSY? (Yes or No)</b><br>_____  |  |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</b><br><input type="checkbox"/>   |                         | <b>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</b><br>_____  |  | <b>21C. WHERE DID INJURY OCCUR?</b><br>(If in Baltimore City, give exact location) |  |
| <b>21D. TIME OF INJURY (APPROX.)</b><br>(Month) (Day) (Year) (Hour)  |                         | <b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | <b>21F. HOW DID INJURY OCCUR?</b><br>_____   |  |
| <b>22. I certify that (I) (this hospital) attended the deceased from 1/24/72 19 to 1/24/72 19 that (I) (we) last saw the deceased alive on 1/24/72 19 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (We) (did) (did not) view the body after death.</b>   |                         |   |  |  |  |
| <b>23A. SIGNATURE</b><br>Theodor C. Wilson MD  |                         |   |  | <b>23B. DATE SIGNED</b><br>1/25/72   |  |
| <b>23C. PHYSICIAN'S NAME (Type)</b><br>Theodor C. Wilson MD  |                         |   |  | <b>23D. ADDRESS</b><br>2600 Liberty Heights Ave.                                   |  |
| <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br>Burial  |                         | <b>24B. DATE</b><br>1/28/72   |  | <b>24C. NAME OF CEMETERY or CREMATORY</b><br>Baltimore Nat'l Cemetery              |  |
| <b>24D. LOCATION</b><br>Baltimore, Maryland  |                         | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br>JAN 28 1972   |  |  |  |
| <b>25B. NAME OF REGISTRAR</b><br>MORTON & DYETT F.H.   |                         | <b>25C. FUNERAL DIRECTOR</b><br>ADDRESS<br>1701 Laurens Street  |  |  |  |

October 5

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| D-120  |  | 72 00951 |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 72 00951 |  |
|--|--|----------|--|---|--|-------------------|--|
| BIRTH NO.  |  |          |  | 1. NAME OF DECEASED<br>(Type or Print) <u>Davis-Bentha</u>  |  |                   |  |
| 2. DATE AND HOUR OF DEATH<br><u>1/25/1972</u> <u>11:00</u> P.M.  |  |          |  | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |                   |  |
| 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Md</u> B. COUNTY <u>Baltimore</u>   |  |          |  | FULL NAME OF HOSPITAL OR INSTITUTION<br><u>Lutheran Hospital</u><br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |  |                   |  |
| C. CITY OR TOWN <u>Baltimore</u>   |  |          |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |                   |  |
| E. STREET AND NUMBER<br><u>940 N Baltimore Street</u>  |  |          |  | 5. SEX <u>F</u> 6. RACE <u>Black</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  |                   |  |
| 8. DATE OF BIRTH <u>11/6/93</u> 9. AGE (in years last birthday) <u>78 yrs</u>  |  |          |  | 10. A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE</u> 10B. KIND OF BUSINESS OR INDUSTRY   |  |                   |  |
| 11. BIRTHPLACE (State or foreign country) <u>South Carolina</u>  |  |          |  | 12. CITIZEN OF WHAT COUNTRY <u>USA</u>  |  |                   |  |
| 13. FATHER'S NAME <u>Henry Wells</u>   |  |          |  | 14. MOTHER'S MAIDEN NAME <u>Caroline Durant</u>   |  |                   |  |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO.</u>   |  |          |  | 16. SOCIAL SECURITY NO.   |  |                   |  |
| 17. INFORMANT <u>Susie Peters</u>  |  |          |  | ADDRESS <u>SAUL</u>   |  |                   |  |
| 18. <u>43671</u> I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br>CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <u>Urinary Infection</u><br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Cerebro Vascular</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><u>Accident</u><br>(C) <u>Senility</u> |  |          |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>11 days</u>  |  |                   |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |          |  |   |  |                   |  |
| 19A. DATE OF OPERATION   |  |          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |                   |  |
| 20A. AUTOPSY? (Yes or No) <u>NO</u>  |  |          |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |                   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  |          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |                   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |          |  |   |  |                   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  |          |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  |                   |  |
| 21F. HOW DID INJURY OCCUR?   |  |          |  |   |  |                   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1/14/72</u> to <u>1/25/72</u> and that (I) (we) last saw the deceased alive on <u>1/25/72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  |          |  |   |  |                   |  |
| 23A. SIGNATURE <u>D.S. Karbhari</u>  |  |          |  | 23B. DATE SIGNED <u>1/25/72</u>   |  |                   |  |
| 23C. PHYSICIAN'S NAME (Type) <u>D.S. KARBHARI</u>  |  |          |  | 23D. ADDRESS <u>Lutheran Hospital</u>   |  |                   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  |          |  | 24B. DATE <u>1/29/72</u>  |  |                   |  |
| 24C. NAME OF CEMETERY OR CREMATORY <u>Arbutus Mem. Park</u>  |  |          |  | 24D. LOCATION (City, town, or county) (State) <u>Arbutus Md.</u>  |  |                   |  |
| 25A. DATE RECEIVED BY HEALTH DEPT. <u>JAN 28 1972</u>  |  |          |  | 25B. NAME OF REGISTRAR <u>Robert E. Taylor, M.D.</u>  |  |                   |  |
| 25C. FUNERAL DIRECTOR <u>Porting Byett F.H.</u>  |  |          |  | ADDRESS <u>1701 Laurens St.</u>   |  |                   |  |

11 6 98 18

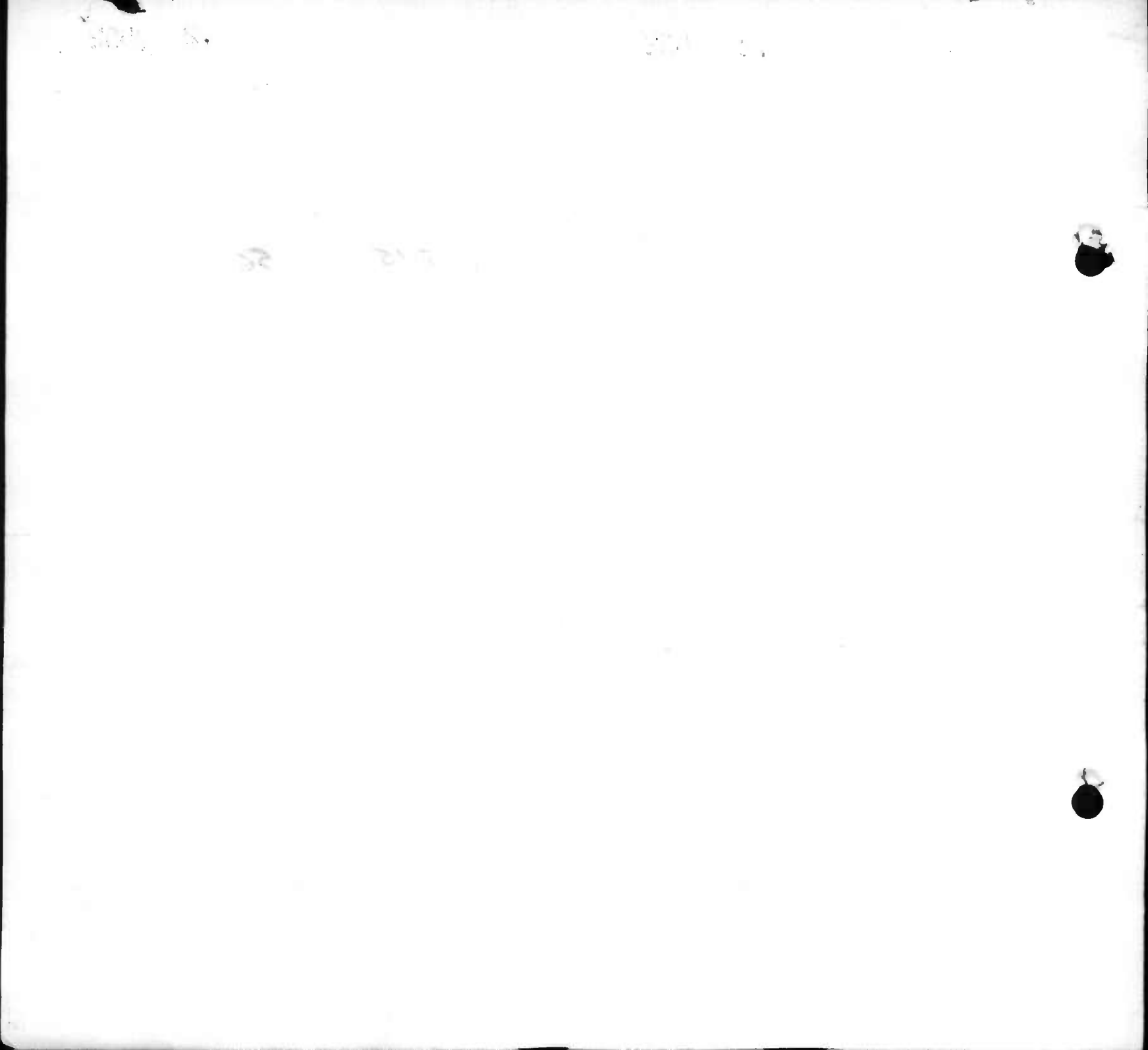
Green line

Good work

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

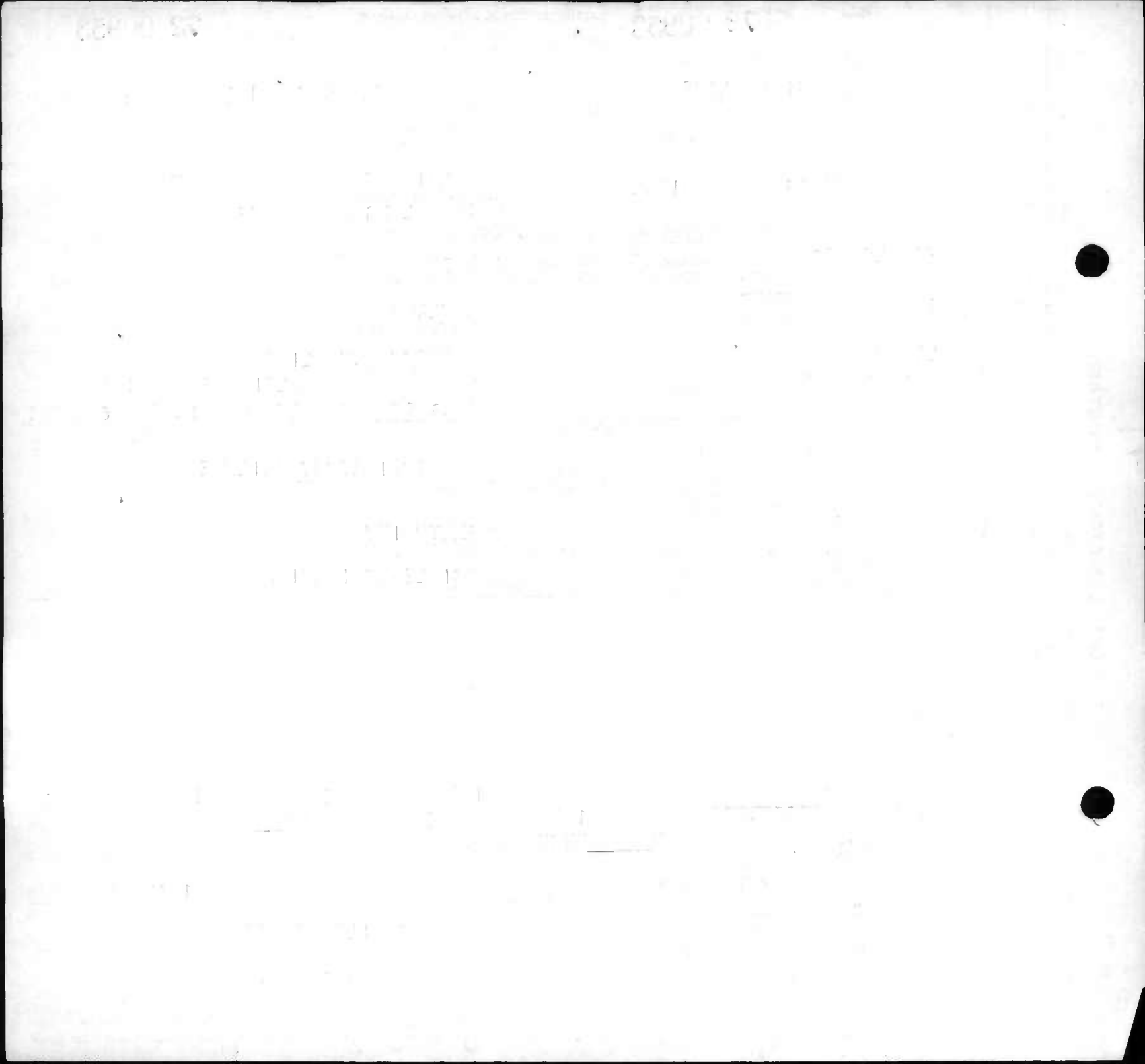
| B-652   |                     | 72 00952  |                                     | BALTIMORE CITY HEALTH DEPARTMENT  |                       | REG. NO. 72 00952  |                     |
|---|---------------------|---|-------------------------------------|---|-----------------------|--|---------------------|
| BIRTH NO.   |                     |   |                                     | CERTIFICATE OF DEATH  |                       |  |                     |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Joseph BRUNSON</u>  |                     |   |                                     | 2. DATE AND HOUR OF DEATH<br><u>1-25-72</u> <u>1:30 A.M.</u>  |                       |  |                     |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>Montebello State Hospital</u>   |                     |   |                                     | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>BALTO</u> B. COUNTY <u>PRWAY</u><br>C. CITY OR TOWN <u>BALTO-21229</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>630 Wildwood PRWAY 1608</u> |                       |  |                     |
| 5. SEX<br><u>M</u>  | 6. RACE<br><u>N</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11/25/15</u> | 9. AGE (In years last birthday)<br><u>56</u>  | If Under 1 Yr. Months | If Under 24 Hrs. Days  | If Under 1 Hr. Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Unemployed</u>  |                     | 10B. KIND OF BUSINESS OR INDUSTRY   |                                     | 11. BIRTHPLACE (State or foreign country)<br><u>Richmond, Virginia</u>  |                       | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S. A.</u>                             |                     |
| 13. FATHER'S NAME<br><u>William Brunson</u>   |                     |   |                                     | 14. MOTHER'S MAIDEN NAME<br><u>Daisy Holt</u>   |                       |  |                     |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <u>No.</u>  |                     | 16. SOCIAL SECURITY NO.   |                                     | 17. INFORMANT<br><u>Mrs. Sallie Miller 2412 Cranah Ave</u>  |                       |  |                     |
| 18. <u>15381</u> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osihenio, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                     |   |                                     | (A) IMMEDIATE CAUSE<br><u>SEPTICEMIA</u><br>DUE TO, OR AS A CONSEQUENCE OF:   |                       | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>3 DAYS</u>              |                     |
|   |                     |   |                                     | (B) <u>URINARY TRACT INFECTION</u><br>DUE TO, OR AS A CONSEQUENCE OF:   |                       | <u>? MONTHS</u>  |                     |
|   |                     |   |                                     | (C) <u>CARCINOMA OF COLON</u>   |                       | <u>2 YEARS</u>   |                     |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><u>CVA &amp; PSEUDOPULSAR DALSY</u>   |                     |   |                                     |   |                       | <u>3 YEARS</u>   |                     |
| 19A. DATE OF OPERATION<br><u>0</u>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     | 20A. AUTOPSY? (Yes or No)<br><u>? NO</u>  |                       | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?       |                     |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                     | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |                       |  |                     |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                     | 21F. HOW DID INJURY OCCUR   |                       |  |                     |
| 22. I certify that (I) (this hospital) attended the deceased from <u>10-27</u> 19 <u>71</u> to <u>1-25</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1-25-</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.             |                     |   |                                     |   |                       |  |                     |
| 23A. SIGNATURE<br><u>Jaime F. Castellanos M.D.</u>  |                     |   |                                     | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>   |                       | 23B. DATE SIGNED<br><u>1-25-72</u>   |                     |
| 23C. PHYSICIAN'S NAME (Type)<br><u>JAIME F. CASTELLANOS M.D.</u>  |                     |   |                                     | 23D. ADDRESS<br><u>MONTABELLO STATE HOSPITAL</u>  |                       |  |                     |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>   |                     | 24B. DATE<br><u>1/29/72</u>   |                                     | 24C. NAME OF CEMETERY or CREMATORY<br><u>Mt. Calvary Cem.</u>   |                       | 24D. LOCATION (City, town, or county) (State)<br><u>A.A. Co., Maryland</u> |                     |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>JAN 28 1972</u>   |                     | 25B. NAME OF REGISTRAR<br><u>F. V. ...</u>  |                                     | 25C. FUNERAL DIRECTOR<br><u>Morton S. Dyett F.H.</u>  |                       | ADDRESS<br><u>1701 Laurens St.</u>   |                     |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |  |
|--|--|---|--|
| <div style="display: flex; justify-content: space-between;"> <span>0-416</span> <span>72 00953</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>   |  | REG. NO. <span style="font-size: 1.2em;">72 00953</span>  |  |
| BIRTH NO. <span style="font-size: 1.2em;">72-00845</span>  |  | 2. DATE AND HOUR OF DEATH<br><div style="display: flex; justify-content: space-between;"> <span>JANUARY 4 1972</span> <span>3:00 P. M.</span> </div>  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">BABY GIRL OLIVER</span>   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <span style="font-size: 1.2em;">MARYLAND</span><br>B. COUNTY <span style="font-size: 1.2em;">1506</span>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.2em;">40</span> <span style="font-size: 1.2em;">ST AGNES HOSPITAL</span> </div>  |  | C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span><br>D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| 5. SEX <span style="font-size: 1.2em;">FEMALE</span><br>6. RACE <span style="font-size: 1.2em;">NEGRO</span><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <span style="font-size: 1.2em;">1 4 72</span><br>9. AGE (In years last birthday) <span style="font-size: 1.2em;">2</span><br>If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">NEWBORN</span>  |  | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">MARYLAND</span>  |  |
| 13. FATHER'S NAME<br><span style="font-size: 1.2em;">LARRY</span>  |  | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">DOROTHY MAY OLIVER</span>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.   |  |
| 17. INFORMANT<br><span style="font-size: 1.2em;">BALTIMORE MD 21229</span>   |  | 18. CAUSE OF DEATH<br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p><span style="font-size: 1.2em;">776.0 I</span><br/>           DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br/>           (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br/>           ANTECEDENT CAUSES<br/>           DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> </div> <div style="width: 35%;"> <p>RESPIRATORY FAILURE<br/>           (A) IMMEDIATE CAUSE<br/>           DUE TO, OR AS A CONSEQUENCE OF:<br/>           PREMATURITY<br/>           (B) DUE TO, OR AS A CONSEQUENCE OF:<br/>           POSSIBLE ASPIRATION<br/>           (C)</p> </div> </div> |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY? (Yes or No)<br><span style="font-size: 1.2em;">NO</span>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (X) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1 4</span> 19 <span style="font-size: 1.2em;">72</span> to <span style="font-size: 1.2em;">1 4</span> 19 <span style="font-size: 1.2em;">72</span> that (X) (we) lost saw the deceased olive on <span style="font-size: 1.2em;">1 4</span> 19 <span style="font-size: 1.2em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. |  |   |  |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">J. Aziz M.D.</span>  |  | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">01 17 72</span>   |  |
| 23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">P. Aziz M.D.</span>   |  | 23D. ADDRESS<br><span style="font-size: 1.2em;">CATON &amp; WILKENS AVENUE</span>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">Burial</span>  |  | 24B. DATE<br><span style="font-size: 1.2em;">1/24/72</span>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><span style="font-size: 1.2em;">New Cathedral</span>   |  | 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">Baltimore, Maryland</span>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">JAN 28 1972</span>  |  | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">V. E. Gadsden, M.D.</span>  |  |
| 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">Witzke, 1630 Edmondson Avenue</span>  |  | ADDRESS<br><span style="font-size: 1.2em;">21228</span>   |  |





FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |   |  |   |
|---|---|--|---|
| <p><b>0-165</b> <b>72 00954</b> <b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p style="font-size: 1.2em; font-weight: bold;">CERTIFICATE OF DEATH</p>  |   | <p>REG. NO. <b>72 00954</b></p>  |   |
| <p>BIRTH NO. <b>0-165</b></p>   |   | <p>2. DATE AND HOUR OF DEATH<br/><b>1-26-72 4 40 A.M.</b></p>  |   |
| <p>1. NAME OF DECEASED<br/>(Type or Print) <b>MR CARL OBERHEIM</b></p>  |   | <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br/>A. STATE <b>MARYLAND</b> B. COUNTY <b>Balto</b></p>         |   |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br/><b>BON Secours Hospital</b></p>   |   | <p>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>                       |   |
| <p>FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br/><b>BON Secours Hospital</b></p>  |   | <p>E. STREET AND NUMBER<br/><b>304 Westshore Rd 21229</b></p>  |   |
| <p>5. SEX<br/><b>M</b></p>  | <p>6. RACE<br/><b>W</b></p>   | <p>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br/>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p> | <p>8. DATE OF BIRTH<br/><b>05/07/96</b></p>                                 |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br/><b>RETIRED-U.S. GOVT.</b></p>  |   | <p>11. BIRTHPLACE (State or foreign country)<br/><b>Maryland</b></p>   | <p>9. AGE (In years lost birthday)<br/><b>75</b></p>                        |
| <p>13. FATHER'S NAME<br/><b>AUGUST OBERHEIM</b></p>   |   | <p>12. CITIZEN OF WHAT COUNTRY?<br/><b>USA</b></p>   |   |
| <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)</p>   |   | <p>16. SOCIAL SECURITY NO.</p>   | <p>14. MOTHER'S MAIDEN NAME<br/><b>MARY Dounys Doenges</b></p>              |
| <p>18. <b>412.31+25017</b><br/>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br/>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br/><b>ATHEROSCLEROTIC HEART DISEASE</b></p>   |   | <p>CAUSE OF DEATH<br/>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br/><b>ATHEROSCLEROTIC HEART DISEASE</b></p>                                   |   |
| <p>ANTECEDENT CAUSES<br/>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br/><b>II</b></p>  |   | <p>(B) <b>Cerebro-vascular accident, diabetes mellitus</b><br/>DUE TO, OR AS A CONSEQUENCE OF:</p>   |   |
| <p>(C) <b>and urinary tract infection.</b></p>  |   | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</p>  |   |
| <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>   |   |  |   |
| <p>19A. DATE OF OPERATION</p>   | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>   | <p>20A. AUTOPSY? (Yes or No)</p>   | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p> |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>  | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>                | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>  |   |
| <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>  | <p>21E. INJURY OCCURRED While At <input type="checkbox"/> Work Not While At Work <input type="checkbox"/></p> | <p>21F. HOW DID INJURY OCCUR?</p>  |   |
| <p>22. I certify that <b>HY</b> (this hospital) attended the deceased from <b>January 15 1972</b> to <b>January 26 1972</b> that <b>HY</b> (we) lost saw the deceased alive on <b>January 26 1972</b> and that in <b>my</b> (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p> |   |  |   |
| <p>23A. SIGNATURE<br/><b>Th Th Th</b></p>   |   | <p>23B. DATE SIGNED<br/><b>January 26, 1972</b></p>  | <p>23C. PHYSICIAN'S NAME (Type)<br/><b>THIRN THITIVARANA</b></p>            |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)<br/><b>Burial</b></p>   |   | <p>24B. DATE<br/><b>1/29/72</b></p>  | <p>24C. NAME of CEMETERY or CREMATORY<br/><b>Louisa Park Cemetery</b></p>   |
| <p>25A. DATE REC'D BY HEALTH DEPT.<br/><b>JAN 28 1972</b></p>   |   | <p>25B. NAME OF REGISTRAR<br/><b>Witzke</b></p>  | <p>25C. FUNERAL DIRECTOR<br/><b>Edmondson Avenue 21228</b></p>              |
| <p>24D. LOCATION (City, town, or county) (State)<br/><b>Baltimore, Maryland</b></p>   |   | <p>25D. ADDRESS<br/><b>Edmondson Avenue 21228</b></p>  |   |

173 - 51

173 - 51

173 - 51

**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

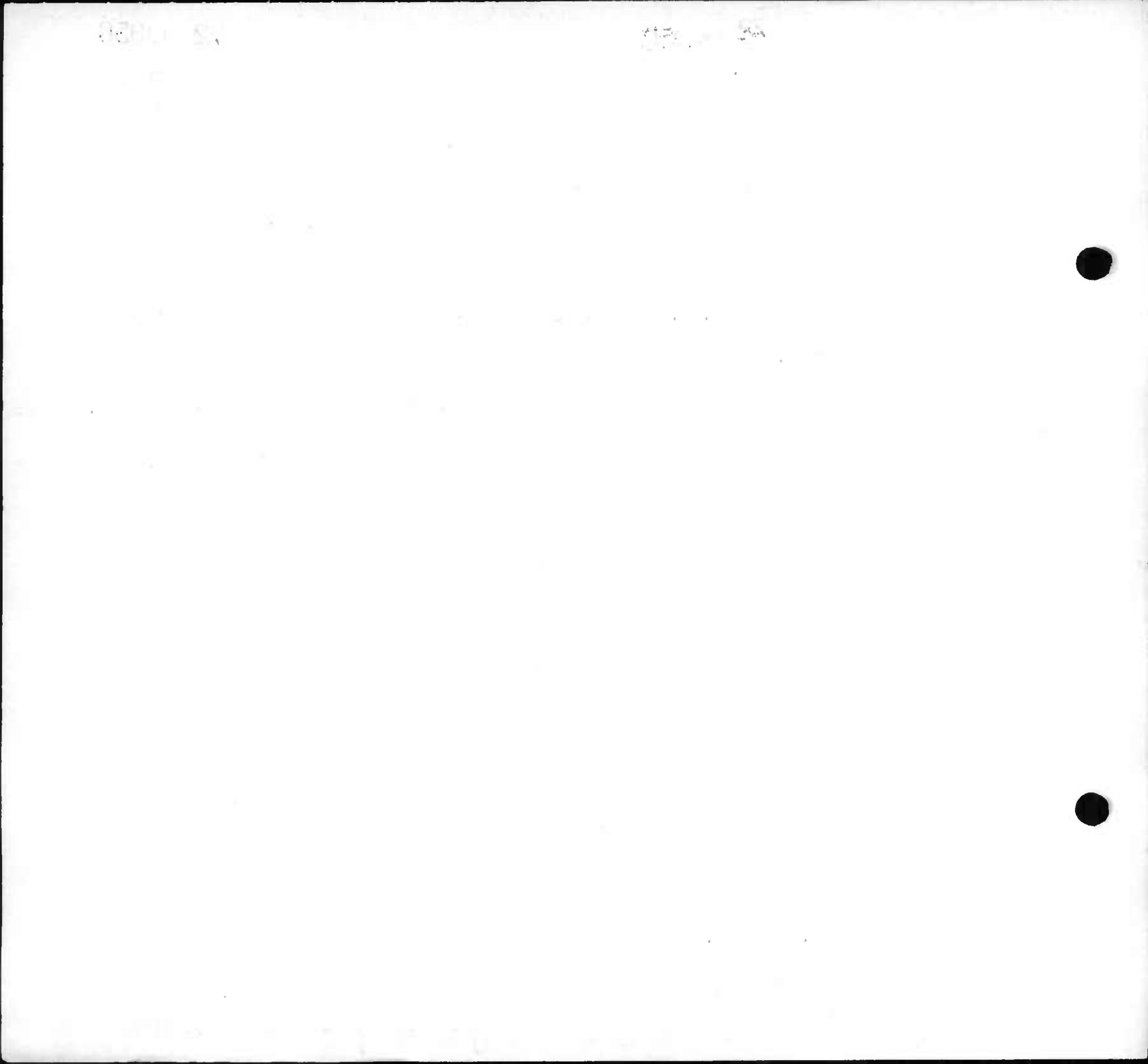
| K-120   |                     | 72 00955  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | CERTIFICATE OF DEATH   |  | X REG. NO. 72 00955                                       |  |
|---|---------------------|---|--|---|--|--|--|---|--|
| BIRTH NO.   |                     | 1. NAME OF DECEASED<br>(Type or Print) <b>MARION KOUBIK</b>   |  |   |  | 2. DATE AND HOUR OF DEATH<br><b>1/26/72 10:20 A.M.</b>   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>South BALTIMORE GEN. HOSP.</b>  |                     |   |  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD</b> B. COUNTY <b>BALTO</b><br>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>5508 CALVERT RD</b> |  |   |  |
| 5. SEX<br><b>F</b>  | 6. RACE<br><b>W</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>4-30-11</b>  |  | 9. AGE (In years last birthday)<br><b>60</b>   |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min. |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |                     | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Housewife</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>USA</b>                     |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |   |  |
| 13. FATHER'S NAME<br><b>(Dec) Claude V. Hillsinger</b>  |                     |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Nellie Shepherd</b>                          |  |  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                     | 16. SOCIAL SECURITY NO.<br><b>216-40-6300</b>   |  | 17. INFORMANT<br><b>James V. Koubik</b>                                     |  |  |  | ADDRESS<br><b>5508 Calvert Rd. 21207</b>                  |  |
| 18. <b>153.8</b> I <b>1</b> CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Terminal Carcinoma</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Colon Carcinoma</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>8 yrs.</b> |                     |   |  |   |  |  |  |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>_____   |                     |   |  |   |  |  |  |   |  |
| 19A. DATE OF OPERATION<br><b>1/26/72</b>  |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br><b>Ca - Colon</b>   |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location) |  |  |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                     | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |   |  |
| 22. I certify that <b>(A)</b> (this hospital) attended the deceased from <b>1/23</b> 19 <b>72</b> to <b>1/26</b> 19 <b>72</b> , that <b>(A)</b> (we) last saw the deceased alive on <b>1/26</b> 19 <b>72</b> and that in <b>(A)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(A)</b> (We) <b>(A)</b> (do not) view the body after death.  |                     |   |  |   |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Cesar T. Climaco</b> DEGREE  |                     |   |  |   |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/>  |  | 23B. DATE SIGNED<br><b>1/26/72</b>                        |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>CESAR T. CLIMACO</b> DEGREE  |                     |   |  | 23D. ADDRESS<br><b>2502 W. PATAPSCO AVE. MD</b>                             |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                     | 24B. DATE<br><b>1/29/72</b>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Lorraine Park</b>                  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Woodlawn, Md.</b>  |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1972</b>   |                     | 25B. NAME OF REGISTRAR<br><b>R. E. G. G. G.</b>   |  | 25C. FUNERAL DIRECTOR<br><b>Witzke</b>                                      |  |  |  | ADDRESS<br><b>1630 Edmondson Avenue 21228</b>             |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| R-200   |                         | 72 00956  |                                    | BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |  | REG. NO. 72 00956  |  |
|---|-------------------------|---|------------------------------------|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Henry Ross</b>  |                         |   |                                    | 2. DATE AND HOUR OF DEATH<br><b>1/26/1972</b>  |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>D.O.A. Maryland General Hospital</b>  |                         |   |                                    | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>2531</b><br>C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>5105 Williston Street</b> |  |  |  |
| 5. SEX<br><b>male</b>   | 6. RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>5/20/05</b> |  | 9. AGE (in years last birthday)<br><b>66</b> | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min.                        |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>U. S. Government</b>  |                                    | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>                                       |  |
| 13. FATHER'S NAME<br><b>Late George W. Ross</b>   |                         |   |                                    | 14. MOTHER'S MAIDEN NAME<br><b>Late Laura</b>  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |                         | 16. SOCIAL SECURITY NO.   |                                    | 17. INFORMANT ADDRESS<br><b>Mrs. Mildred Ross, 5908 Franklin Ave. Apt 2B</b>   |  |  |  |
| 18. <b>410.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Coronary Occlusion</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                         |   |                                    | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>ASHD with CHF</b>   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>Hours</b><br><br><b>Years</b> |  |
| 19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |   |                                    |  |  |  |  |
| 19A. DATE OF OPERATION  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?             |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                    | 21F. HOW DID INJURY OCCUR?   |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>February 1969</b> to <b>1/27/1972</b> that (I) (we) last saw the deceased alive on <b>1/17/1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                         |   |                                    |  |  |  |  |
| 23A. SIGNATURE<br><b>Dr. Adnan M. Sonmez</b>  |                         |   |                                    | 23B. DATE SIGNED<br><b>1/27/72</b>   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>Dr. Adnan M. Sonmez</b>                       |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>1/29/72</b>   |                                    | 24C. NAME of CEMETERY or CREMATORY<br><b>Western</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Maryland</b>      |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1972</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Witzke</b>   |                                    | 25C. FUNERAL DIRECTOR ADDRESS<br><b>1630 Edmondson Ave., 21228</b>   |  |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                                |   |   | REG. NO. <b>72 00957</b>  |
|---|--------------------------------|---|---|---|
| <b>1. NAME OF DECEASED</b><br>(Type or Print)<br><b>JOHN J. WALLNER</b>   |                                | <b>2. DATE AND HOUR OF DEATH</b><br><b>January 26, 1972</b> <b>4<sup>00</sup> P.</b> M.   |   |   |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>House In The Pines Nursing Home</b><br><b>5837 Belair Rd.</b><br><b>Baltimore, 21206, Md.</b>  |                                | <b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Md.</b> B. COUNTY _____<br><b>2607</b><br>C. CITY OR TOWN <b>Baltimore</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>643 S. Oldham St. # 21224.</b>                             |   |   |
| <b>5. SEX</b><br><b>Male</b>  | <b>6. RACE</b><br><b>White</b> | <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>   | <b>8. DATE OF BIRTH</b> <b>May 31, 1886</b> <b>85</b><br><b>9. AGE</b> (In years last birthday) |   |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>Retired</b>  |                                | <b>10B. KIND OF BUSINESS OR INDUSTRY</b><br><b>Beth. Steel Co.</b>  |   | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>Czechoslovakia</b>                                       |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>U.S.A.</b>  |                                | <b>13. FATHER'S NAME</b><br><b>? Wallner</b>  |   |   |
| <b>14. MOTHER'S MAIDEN NAME</b><br><b>Unknown</b>   |                                | <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>  |   |   |
| <b>16. SOCIAL SECURITY NO.</b><br><b>213-07-5209</b>  |                                | <b>17. INFORMANT</b><br><b>Joseph W. Wallner :</b>  |   |   |
| <b>18. CAUSE OF DEATH</b><br><b>412.3 I</b><br><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Anteromedullary Head Disease</b><br><b>ANTECEDENT CAUSES</b><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>Generalized Arteriosclerosis</b>                                     |                                | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br><b>—</b><br><b>yes</b>   |   |   |
| <b>II</b><br><b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b><br><b>Chronic Obstructive Emphysema; Left Jugular Hernia</b>   |                                | <b>yes</b>  |   |   |
| <b>19A. DATE OF OPERATION</b><br><b>0</b>   |                                | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>   |   | <b>20A. AUTOPSY? (Yes or No)</b><br><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b> |
| <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner)<br><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)<br><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)<br><b>21E. INJURY OCCURRED</b><br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/><br><b>21F. HOW DID INJURY OCCUR?</b> |                                | <b>22. I certify that (I) (the hospital) attended the deceased from</b> <b>12/3/1971</b> <b>to</b> <b>1/26/1972</b> ,<br><b>that (I) (we) last saw the deceased alive on</b> <b>1/25/1972</b> <b>and that in (my) (our) opinion death occurred on the date</b><br><b>and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> |   |   |
| <b>23A. SIGNATURE</b><br><b>Albert B. Bradley</b>   |                                | <b>23B. DATE SIGNED</b><br><b>1/28/72</b>   |   | <b>23C. PHYSICIAN'S NAME (Type)</b><br><b>ALBERT B. BRADLEY</b>   |
| <b>23D. ADDRESS</b><br><b>4900 Belair Rd., Balto., 21206, Md.</b>   |                                | <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>  |   |   |
| <b>24B. DATE</b><br><b>1-29-72</b>  |                                | <b>24C. NAME OF CEMETERY OR CREMATORY</b><br><b>Sacred Heart Cemetery</b>   |   |   |
| <b>24D. LOCATION</b> (City, town, or county) (State)<br><b>7401 German Hill Rd., Ba. Co., Md.</b>   |                                | <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>25B. NAME OF REGISTRAR</b><br><b>25C. FUNERAL DIRECTOR, ADDRESS</b><br><b>6224 Eastern Ave. Balto., 21224, Md.</b>   |   |   |
| <b>25D. DATE REC'D BY HEALTH DEPT.</b><br><b>25E. NAME OF REGISTRAR</b><br><b>25F. FUNERAL DIRECTOR, ADDRESS</b>  |                                |   |   |   |

• • • • •



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                  |  |                                 |
|--|------------------|--|---------------------------------|
| BALTIMORE CITY HEALTH DEPARTMENT   |                  | REG. NO. <u>72 00958</u>   |                                 |
| M-255 72 00958   |                  | CERTIFICATE OF DEATH   |                                 |
| 1. NAME OF DECEASED<br>(Type or Print) <u>Mc MANUS, MARY T.</u>  |                  | 2. DATE AND HOUR OF DEATH<br><u>1-25-1972 14.25 PM.</u>  |                                 |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u>             |                                 |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>44 UNION MEMORIAL HOSPITAL</u>  |                  | C. CITY OR TOWN <u>TOWSON</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                                 |                                 |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |                  | E. STREET AND NUMBER <u>8245 SCARLETT DR.</u>  |                                 |
| 5. SEX <u>F</u>  | 6. RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5-28-92</u> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETIRED</u>   |                  | 9. AGE (in years last birthday) <u>79</u>  |                                 |
| 10B. KIND OF BUSINESS OR INDUSTRY  |                  | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>  |                                 |
| 13. FATHER'S NAME <u>GEORGE D. SMITH</u>   |                  | 12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>   |                                 |
| 14. MOTHER'S MAIDEN NAME <u>ANN HIGHLAND</u>   |                  | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>                                       |                                 |
| 16. SOCIAL SECURITY NO. <u>215-48-2000</u>   |                  | 17. INFORMANT <u>MR. JAMES McMANUS</u> ADDRESS <u>118 EDGEWOOD RD 21204</u>  |                                 |
| 18. <u>427.01</u> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |                  | CAUSE OF DEATH   |                                 |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  |                  | (A) IMMEDIATE CAUSE <u>CVA</u><br>DUE TO, OR AS A CONSEQUENCE OF:  |                                 |
| ANTECEDENT CAUSES  |                  | (B) <u>C.H.F.</u><br>DUE TO, OR AS A CONSEQUENCE OF:   |                                 |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                  | (C) _____  |                                 |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                  |  |                                 |
| 19A. DATE OF OPERATION   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                 |
| 20A. AUTOPSY? (Yes or No)  |                  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                                 |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                 |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)  |                                 |
| 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                  | 21F. HOW DID INJURY OCCUR?   |                                 |
| 22. I certify that (I) (this hospital) attended the deceased from <u>01-24</u> 19 <u>72</u> to <u>01-25</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>01-25</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                  |  |                                 |
| 23A. SIGNATURE <u>[Signature]</u>  |                  | 23B. DATE SIGNED <u>4-25-1972</u>  |                                 |
| 23C. PHYSICIAN'S NAME (Type) <u>GHASSAN NAHAS M.D.</u>   |                  | 23D. ADDRESS <u>UNION MEMORIAL HOSPITAL-BALTO-MD</u>   |                                 |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u>   |                  | 24B. DATE <u>1-29-72</u>   |                                 |
| 24C. NAME OF CEMETERY OR CREMATORY <u>DRUID RIDGE CEMETERY</u>   |                  | 24D. LOCATION (City, town, or county) (State) <u>PIKESVILLE, BALT. MD.</u>   |                                 |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1972</u>   |                  | 25B. NAME OF REGISTRAR <u>Valerie E. Garber, R.D.</u>  |                                 |
| 25C. FUNERAL DIRECTOR <u>Raymond J. Curran</u>   |                  | ADDRESS <u>817 SCARLETT DR TOWSON, MD 21204</u>  |                                 |

NOV 2 1964

WASH DC

TO DIRECTOR, FBI (100-374301) FROM SAC, NEW YORK (100-100000) (P)

RE NEW YORK TELETYPE TO BUREAU, OCTOBER TWENTY, SIXTYFOUR.

RE NEW YORK TELETYPE TO BUREAU, OCTOBER TWENTY, SIXTYFOUR.

RE NEW YORK TELETYPE TO BUREAU, OCTOBER TWENTY, SIXTYFOUR.

RE NEW YORK TELETYPE TO BUREAU, OCTOBER TWENTY, SIXTYFOUR.

END

W

100-374301-100000

100-374301-100000

100-374301-100000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |   |  |
|---|--|---|--|
| <div style="display: flex; justify-content: space-between;"> <span><b>S-435</b></span> <span><b>72 00959</b></span> <span><b>BALTIMORE CITY HEALTH DEPARTMENT</b></span> </div> <div style="text-align: center;"> <b>CERTIFICATE OF DEATH</b> </div>  |  | <b>72 00959</b><br>REG. NO.   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>SHELTON, HORACE E. Sr.</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>1/26/72 9:36 PM</b>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>33 The Johns Hopkins Hospital<br/>Baltimore, Maryland 21205</b>   |  | 4. USUAL RESIDENCE (Where deceased lived. If institutional residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>908</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>1226 BONAPARTE AVENUE</b>                           |  |
| 5. SEX <b>M</b><br>6. RACE <b>N</b><br>7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH <b>08/17/93</b><br>9. AGE (In years last birthday) <b>78</b><br>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b><br>11. BIRTHPLACE (State or foreign country) <b>Hanover Co., Virginia</b><br>12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b> | 13. FATHER'S NAME <b>SHELTON, WILLIAM</b><br>14. MOTHER'S MAIDEN NAME <b>MILES, SARAH</b><br>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <b>no</b><br>16. SOCIAL SECURITY NO. <b>218 07 4733</b><br>17. INFORMANT <b>Mr. Horace Shelton Jr., 1226 Bonaparte Avenue</b><br>ADDRESS <b>21218</b> |  |
| 18. <b>600X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>CARDIO-RESP. ARREST.</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C)   |  |
| 19. DATE OF OPERATION <b>1/17</b><br>19A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>PROSTATIC HYPERTROPHY</b><br>20A. AUTOPSY (Yes or No) <b>No</b><br>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |  |
| 21A. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)<br>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 21D. INJURY OCCURRED<br>White At Work <input type="checkbox"/> Not White At Work <input type="checkbox"/><br>21E. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1972</b> to <b>1972</b> and that (I) (we) last saw the deceased alive on <b>9:36 PM</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |   |  |
| 23A. SIGNATURE <b>MARC D. YOSHIZUMI, M.D.</b><br>23C. PHYSICIAN'S NAME (Type) <b>MARC D. YOSHIZUMI, M.D.</b>  |  | 23B. DATE SIGNED <b>1/26/72</b><br>23D. ADDRESS <b>JOHNS HOPKINS HOSPITAL</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b><br>24B. DATE <b>1-31-1972</b><br>24C. NAME of CEMETERY or CREMATORY <b>Mt. Calvary Cemetery</b><br>24D. LOCATION <b>A.A. Co., Maryland</b>   |  | 25A. DATE REC'D BY HEALTH DEPT. <b>JAN 28 1972</b><br>25B. NAME OF REGISTRAR <b>Robert E. Taylor, Jr.</b><br>25C. FUNERAL DIRECTOR <b>1735 Harford Avenue 21213</b><br>ADDRESS <b>Marshall W. Jones, Jr.</b>  |  |

WILLIAM MORRIS

WILLIAM MORRIS

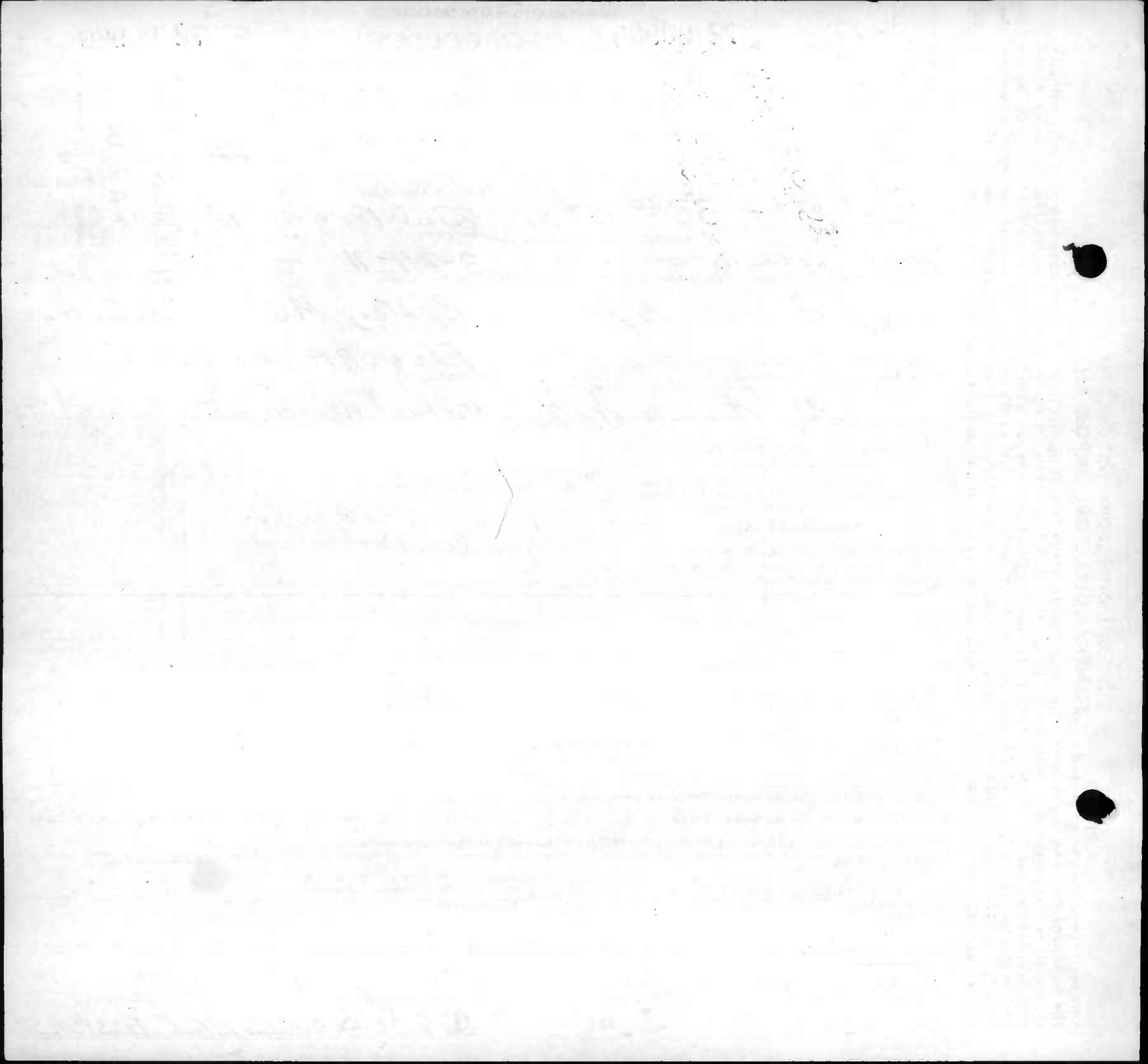
WILLIAM MORRIS

WILLIAM MORRIS

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |          |  |  |  |  |  |   |  | REG. NO.   | 72 00960 |
|--|--|----------|--|--|--|--|--|---|--|--|----------|
| BIRTH NO. <u>W-160</u>   |  | 72 00960 |  | CERTIFICATE OF DEATH   |  |  |  |   |  |  |          |
| 1. NAME OF DECEASED<br>(Type or Print) <u>SCHAD</u><br><u>MICHAEL SHADON WEAVER JR</u>   |  |          |  | 2. DATE AND HOUR OF DEATH<br><u>1-26-72</u> <u>8</u> <u>A</u> M.   |  |  |  |   |  |  |          |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |          |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <u>MARYLAND</u> B. COUNTY <u>906</u> |  |  |  |   |  |  |          |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><u>4-4 Union Memorial Hosp.</u><br><u>Calvert + 38th Sts.</u>   |  |          |  | C. CITY OR TOWN<br><u>BALTIMORE</u>  |  |  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>             |  |  |          |
| E. STREET AND NUMBER<br><u>2760 FENWICK AVENUE</u>   |  |          |  | 5. SEX<br><u>MALE</u>  |  |  |  | 6. RACE<br><u>NEGROID</u>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |          |
| 8. DATE OF BIRTH<br><u>3-24-71</u>   |  |          |  | 9. AGE (In years last birthday)<br><u>10</u>   |  | If Under 1 Yr. Months: Days: Hours: Min. |  | 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>N/A</u> |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>N/A</u>  |          |
| 11. BIRTHPLACE (State or foreign country)<br><u>BALTO., Md.</u>  |  |          |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U. S. A.</u>  |  |  |  |   |  |  |          |
| 13. FATHER'S NAME<br><u>Michael SHADON WEAVER Sr.</u>  |  |          |  | 14. MOTHER'S MAIDEN NAME<br><u>ELENORA MADDOX</u>  |  |  |  |   |  |  |          |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>N/A</u>   |  |          |  | 16. SOCIAL SECURITY NO.<br><u>N/A</u>  |  |  |  | 17. INFORMANT<br><u>Michael Weaver 2824 Federal St.</u>   |  |  |          |
| 18. <u>079-9-1</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>0 Viremia</u>   |  |          |  | CAUSE OF DEATH<br><u>0 Viremia</u>   |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>24 hours</u>   |  |  |          |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>0 Congenital heart disease</u><br><u>- AV. canal</u>  |  |          |  | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><u>0 Down's Syndrome</u>  |  |  |  | (C) <u>Birth</u>  |  |  |          |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |          |  |  |  |  |  |   |  |  |          |
| 19A. DATE OF OPERATION<br><u>0</u>   |  |          |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  |  |  | 20A. AUTOPSY? (Yes or No)<br><u>NO</u>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |          |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |  |          |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  |  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                                  |  |  |          |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  |          |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                              |  |  |  | 21F. HOW DID INJURY OCCUR?  |  |  |          |
| 22. I certify that (I) (this hospital) attended the deceased from <u>3/24</u> <u>1971</u> to <u>1/26</u> <u>1972</u> , that (I) (we) last saw the deceased alive on <u>1/25</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |          |  |  |  |  |  |   |  |  |          |
| 23A. SIGNATURE<br><u>M. Harris Blue MD</u>   |  |          |  |  |  |  |  | 23B. DATE SIGNED<br><u>1-27-72</u>  |  | 23C. PHYSICIAN'S NAME (Type)<br><u>M. Harris Blue MD</u>   |          |
| 23D. ADDRESS<br><u>4000 W. Northern Pkwy</u><br><u>Balto Md 21215</u>  |  |          |  | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |  |  |  |   |  |  |          |
| 24B. DATE<br><u>1-29-72</u>  |  |          |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>ARBUTUS MEM. PK.</u>  |  |  |  | 24D. LOCATION (City, town, or county) (State)<br><u>ARBUTUS, MARYLAND</u>                                 |  |  |          |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>JAN 28 1972</u>  |  |          |  | 25B. NAME OF REGISTRAR<br><u>Robert E. Kelly</u>   |  |  |  | 25C. FUNERAL DIRECTOR<br><u>W. B. SCRUGGS</u>   |  |  |          |
| 25D. ADDRESS<br><u>1412 E. Preston St.</u>   |  |          |  |  |  |  |  |   |  |  |          |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |   |   | REG. NO. <b>72 00961</b>  |  |
|---|-------------------------|---|---|---|--|
| <div style="display: flex; justify-content: space-between;"> <span><b>D. 620</b></span> <span><b>72 00961</b></span> </div>   |                         |   |   |   |  |
| <b>CERTIFICATE OF DEATH</b>   |                         |   |   |   |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |                         | 2. DATE AND HOUR OF DEATH   |   |   |  |
| <b>NELLIE ESTELLE DORSEY</b>  |                         | <b>1-27-72 7:30 P.M.</b>  |   |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)   |   |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br><b>00</b> Residence: Memorial Apts.   |                         | A. STATE<br><b>Maryland</b>   |   |   |  |
|   |                         | B. COUNTY   |   |   |  |
|   |                         | C. CITY OR TOWN<br><b>Baltimore</b>   |   | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |  |
|   |                         | E. STREET AND NUMBER<br><b>Memorial Apts., 301 McMechan St.,</b>  |   |   |  |
| 5. SEX<br><b>Female</b>   | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |   | 8. DATE OF BIRTH<br><b>April 1, 1902</b>  | 9. AGE (In years last birthday)<br><b>69</b> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>NONE</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>NONE</b>  |   | 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore City</b>                            |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                         |   |   |   |  |
| 13. FATHER'S NAME<br><b>Max A. Hoensch</b>  |                         |   | 14. MOTHER'S MAIDEN NAME<br><b>Nellie Snouffer</b>          |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>   |                         |   | 16. SOCIAL SECURITY NO.<br><b>216-18-3595</b>               |   |  |
| 17. INFORMANT: <b>Daughter</b>  |                         |   | ADDRESS<br><b>Mrs. Jack F. Stidham, 2217 Huntingdon Av.</b> |   |  |
| 18. <b>412.4 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)<br><b>Anteroseptal cardiac vascular disease</b>  |                         | CAUSE OF DEATH  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| ANTECEDENT CAUSES<br><br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                         | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><b>Anteroseptal cardiac vascular disease</b>   |   |   |  |
|   |                         | (B) DUE TO, OR AS A CONSEQUENCE OF:   |   |   |  |
|   |                         | (C) DUE TO, OR AS A CONSEQUENCE OF:   |   |   |  |
| <b>II</b>   |                         |   |   |   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                         |   |   |   |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No)<br><b>no</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>January 1971</b> to <b>January 1972</b> , that (I) (we) lost saw the deceased alive on <b>1-14 1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                         |   |   |   |  |
| 23A. SIGNATURE<br><b>Michael Grassi MD</b>  |                         |   |   | 23B. DATE SIGNED<br><b>1-28-72</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>MICHAEL GRASSI MD</b>  |                         |   |   | 23D. ADDRESS<br><b>Maryland General Hospital and</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                         | 24B. DATE<br><b>1/31/72</b>   |   | 24C. NAME OF CEMETERY OR CREMATORY<br><b>New Cathedral Cemetery Baltimore, Maryland</b>       |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore City</b>  |                         |   |   |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1972</b>   |                         | 25B. NAME OF REGISTRAR<br><b>9720000</b>  |   | 25C. FUNERAL DIRECTOR<br><b>STEWART &amp; MOWEN CO. 108 W. North - City</b>                   |  |

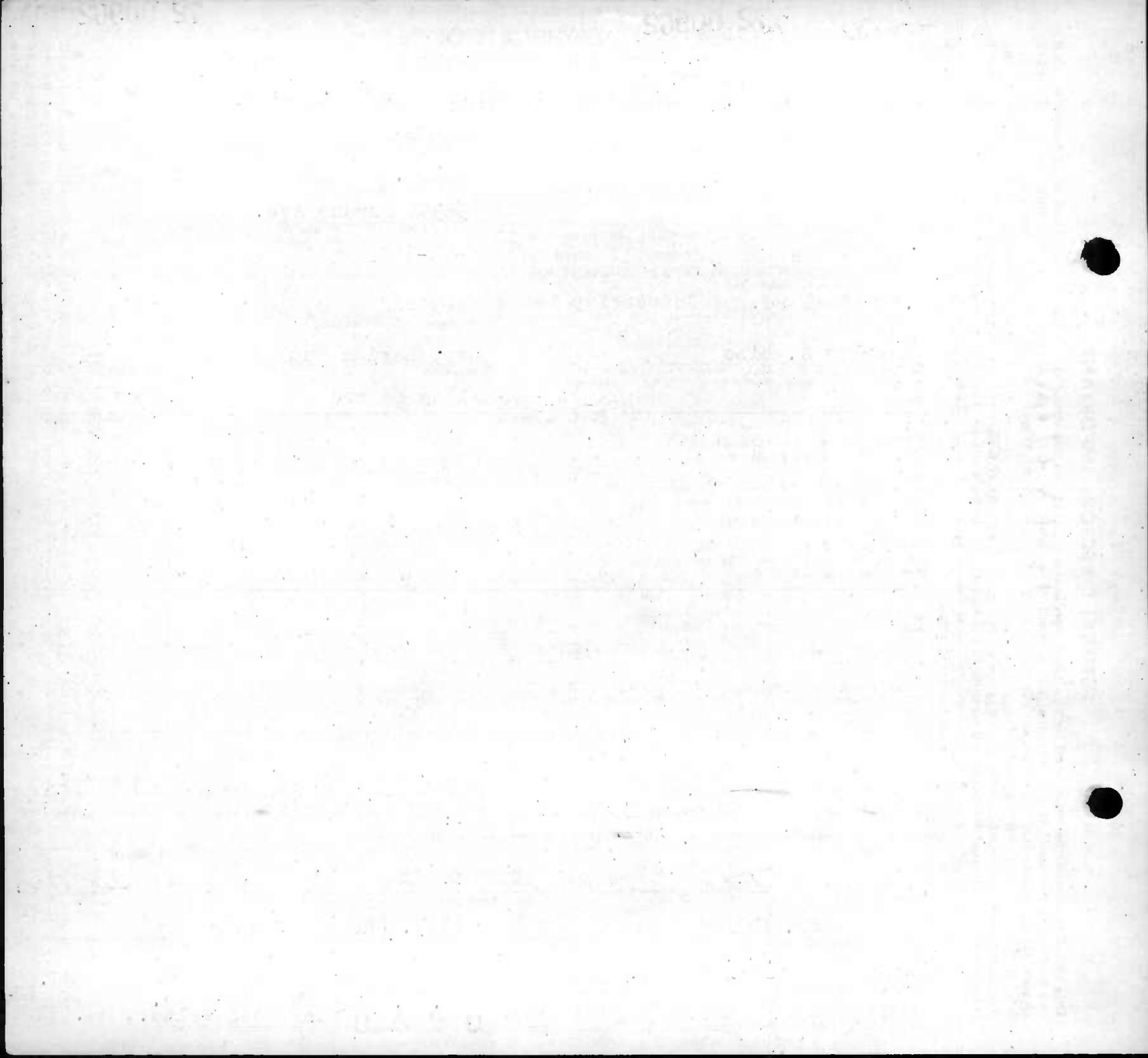
1000000

1000000



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/6B



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

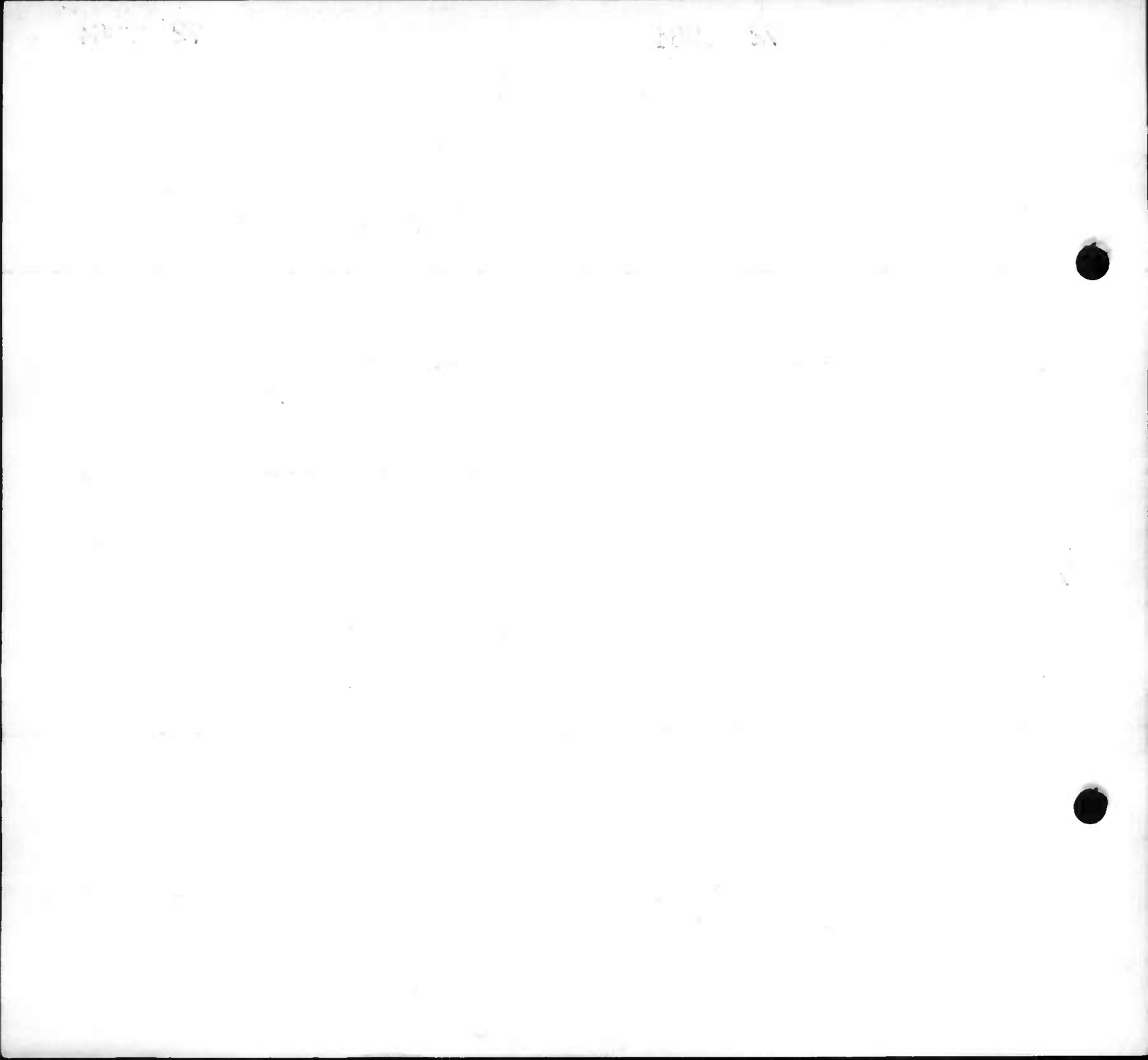
| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH   |  |  |  | REG. NO. <b>72 00963</b>   |
|--|--|--|--|--|
| BIRTH NO. <b>H-635 72 00963</b>  |  |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Hartman Rosella</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>1-21-72</b> <b>6<sup>05</sup> P. M.</b>  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>37 Mercy Hospital</b>  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <b>Md.</b><br>B. COUNTY <b>2642</b> |  |  |
| 5. SEX <b>FEMALE</b>   |  | 6. RACE <b>CAUCASIAN</b>   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |
| 8. DATE OF BIRTH<br><b>7-16-00</b>   |  | 9. AGE (In years last birthday) <b>71</b>  |  | If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.  |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Clerical</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Md.</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>--</b>  |
| 13. FATHER'S NAME<br><b>Charles J. Baumgarten</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Mary Hicks</b>  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>  |  | 16. SOCIAL SECURITY NO.<br><b>219-14-1380</b>  |  | 17. INFORMANT<br><b>Mrs. Mary Ayres (dghtr)</b>  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>410.91</b><br><b>PROB. EARLY MYOCARDIAL INFARCTION</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>MARRIED ASCVD</b><br><b>PULMONARY EDEMA</b>   |  |  |  |  |
| II   |  |  |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |  |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY (Yes or No) <b>YES.</b>   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR (If in Baltimore City, give exact location)  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                               |  | 21F. HOW DID INJURY OCCUR  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1/21</b> 19 <b>72</b> to <b>1/21</b> 19 <b>72</b> that (I) (we) lost saw the deceased alive on <b>1/21</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) <del>did not</del> view the body after death. |  |  |  |  |
| 23A. SIGNATURE<br><b>Phicann F Joaquin</b>   |  | 23B. DATE SIGNED<br><b>1/22/72</b>   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>JOAQUIN</b>   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 24B. DATE<br><b>1/25/72</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Holy Cross Cemetery</b>   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Balto. Md.</b>   |  | 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1972</b>  |  |  |
| 25B. NAME OF REGISTRAR<br><b>Schimunek</b>   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Funeral Homes, Inc. 3331 Brehms Lane, Balto Md. 21213</b>  |  |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |
|--|--|---|
| BALTIMORE CITY HEALTH DEPARTMENT<br><b>CERTIFICATE OF DEATH</b>  |  | REG. NO. <b>72 00964</b>  |
| BIRTH NO. <b>G-650 72-01198</b>  |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Newborn Male Green</b>   |  | 2. DATE AND HOUR OF DEATH<br><b>1/22/72 7:30 AM</b>   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>BON SECOURS HOSPITAL 34</b>  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MD.</b><br>B. COUNTY <b>1902</b> |
| 5. SEX <b>Male</b>   |  | 6. RACE <b>Negro</b>  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 8. DATE OF BIRTH <b>1-22-72</b>   |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 9. AGE (In years last birthday) <b>10</b>   |
| 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)   |
| 13. FATHER'S NAME <b>MARSHAL WYDEL</b>   |  | 14. MOTHER'S MAIDEN NAME <b>Anne Debra Green</b>  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) <input type="checkbox"/> If yes, give war or dates of service  |  | 16. SOCIAL SECURITY NO.   |
| 17. INFORMANT  |  | ADDRESS   |
| 18. <b>726.2 I</b><br>CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>1 hr</b><br><b>1 hr</b>  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  | <b>Immaturity</b>   |
| 19A. DATE OF OPERATION <b>2</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |
| 20A. AUTOPSY? (Yes or No) <b>yes</b>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)   |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>1-22-72</b> to <b>1-22-72</b> that (1) (we) last saw the deceased alive on <b>1-22-72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (did not) view the body after death.  |  |   |
| 23A. SIGNATURE <b>Thara Pongsi</b> M.D. DEGREE   |  | 23B. DATE SIGNED <b>1-22-72</b>   |
| 23C. PHYSICIAN'S NAME (Type) <b>THARA PONGSIRI</b> DEGREE  |  | 23D. ADDRESS <b>Bon Secours Hospital</b>  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <b>CREMATION</b>  | 24B. DATE <b>1/24/72</b>                   | 24C. NAME OF CEMETERY or CREMATORY <b>Bon Secours Hospital</b>  |
| 24D. LOCATION (City, town, or county) <b>2025 W. Fayette St. Balt, Md.</b>   | 24E. STATE <b>15</b>                       |   |
| 25A. DATE REC'D BY HEALTH DEPT. <b>JAN 28 1972</b>   | 25B. NAME OF REGISTRAR <b>Thara Pongsi</b> | 25C. FUNERAL DIRECTOR <b>HOSPITAL DISPOSAL</b>  |



**FUNERAL DIRECTOR: IMPORTANT**

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |   |  |  |  |
|--|--|--|--|---|--|--|--|
| C-52   |  | 72 00965   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 72 00965  |  |
| BIRTH NO.  |  |  |  | 1. NAME OF DECEASED<br>(Type or Print) Mrs. MARY CINCIBUS   |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  | 2. DATE AND HOUR OF DEATH<br>Jan. 24 <sup>th</sup> , 1972 11:45 a.m.  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br>1 Baltimore City Hospital,<br>Baltimore, MD 21224  |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE Maryland<br>B. COUNTY 702   |  | C. CITY OR TOWN<br>Baltimore   |  |
| 5. SEX<br>Female   |  | 6. RACE<br>Caucasian   |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>                       |  | 8. DATE OF BIRTH<br>9-2-1904   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>housewife   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br>at home   |  | 9. AGE (In years last birthday)<br>67   |  | 11. BIRTHPLACE (State or foreign country)<br>Maryland                |  |
| 13. FATHER'S NAME<br>John Harris   |  |  |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>no   |  | 14. SOCIAL SECURITY NO.<br>212-09-8120   |  | 16. MOTHER'S MAIDEN NAME<br>Mary Gosnell (Gosnell)  |  |  |  |
| 17. INFORMANT<br>Wade Cincibus (son) 358 Leeanne Rd.<br>Records: BCH-4940 Eastern Avenue 21224   |  | 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A). |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>(A) IMMEDIATE CAUSE<br>Bronchopneumonia<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) Carcinoma of (L) tonsil & palate 10 yrs.<br>(C) |  |  |  |
| 19A. DATE OF OPERATION<br>0  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br>NO   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (Notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from 1-21-1972 to 1-24-1972 that (I) (we) last saw the deceased alive on 1-24-1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |  |  |   |  |  |  |
| 23A. SIGNATURE<br>Prakash G. Sane  |  |  |  | 23B. DATE SIGNED<br>1-24-72   |  | 23C. PHYSICIAN'S NAME (Type)<br>Prakash G. Sane                      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL   |  | 24B. DATE<br>1/27/72   |  | 24C. NAME OF CEMETERY OR CREMATORY<br>Bohemian National Cemetery  |  | 24D. LOCATION (City, town, or county) (State)<br>Balto. Md.          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>JAN 28 1972   |  | 25B. NAME OF REGISTRAR<br>Robert E. Taylor   |  | 25C. FUNERAL DIRECTOR<br>Schimunek Funeral Homes, Inc.  |  | ADDRESS<br>3331 Brehms Lane, Balto Md 21213                          |  |

Continued from page 1  
Continued from page 1

Continued from page 1

Continued from page 1

Continued from page 1

Continued from page 1

Continued from page 1

Continued from page 1

Continued from page 1

Continued from page 1

Continued from page 1



72 00966

BALTIMORE CITY HEALTH DEPARTMENT  
CERTIFICATE OF DEATH

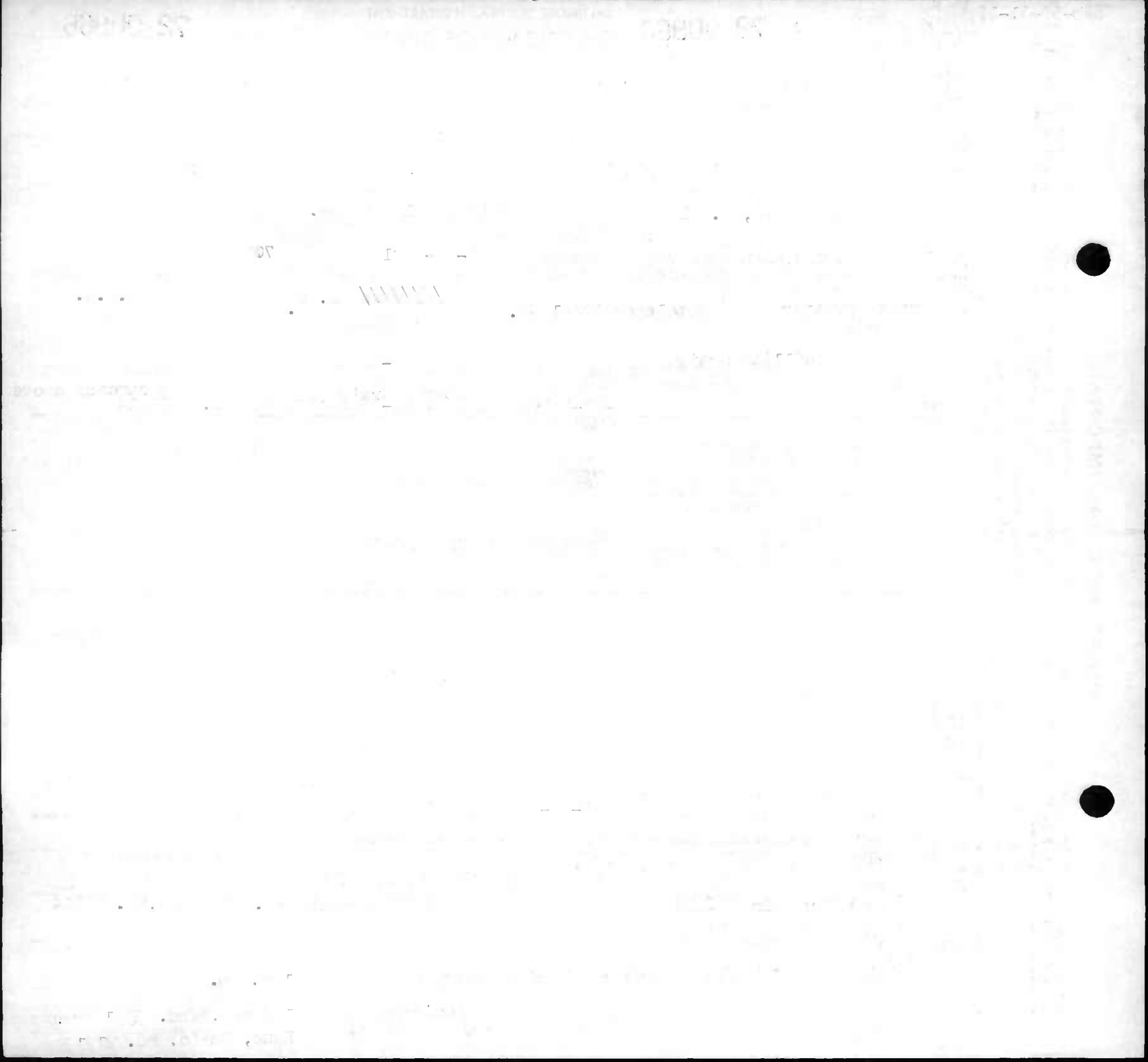
REG. NO.

72 00966

## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

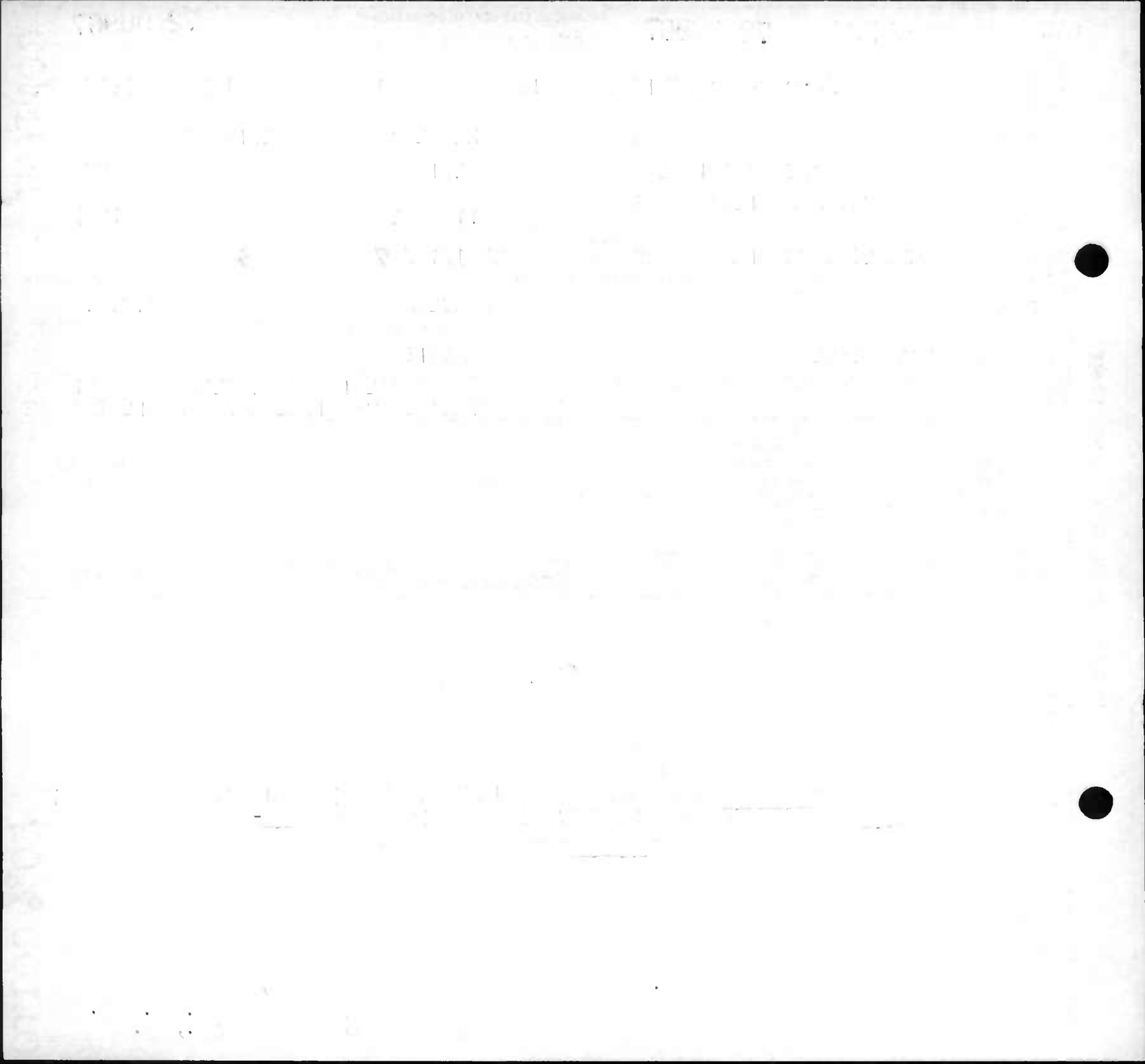
|  |                             |   |                                       |   |                            |  |                             |          |  |
|--|-----------------------------|---|---------------------------------------|---|----------------------------|--|-----------------------------|----------|--|
| C-620  |                             | 72 00966  |                                       | BALTIMORE CITY HEALTH DEPARTMENT  |                            | REG. NO.   |                             | 72 00966 |  |
| BIRTH NO.  |                             | 1. NAME OF DECEASED<br>(Type or Print) <u>Thomas Craig</u>  |                                       |   |                            | 2. DATE AND HOUR OF DEATH<br><u>1-23-72 11:00 P.M.</u>   |                             |          |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <u>Maryland</u><br>B. COUNTY <u>2643</u>                  |                                       |   |                            | 5. CITY OR TOWN <u>Baltimore</u><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                             |          |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>31</u> <u>Baltimore City Hospitals</u><br><u>4940 Eastern Avenue</u><br><u>Baltimore, Md. 21224</u>   |                             | E. STREET AND NUMBER<br><u>3855 Elmley Ave.</u> <u>21213</u>  |                                       |   |                            |  |                             |          |  |
| 5. SEX<br><u>Male</u>  | 6. RACE<br><u>Caucasian</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>11-20-1901</u> | 9. AGE (In years last birthday) <u>70</u>   | If Under 1 Yr. Months Days |  | If Under 24 Hrs. Hours Min. |          |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>Crane Operator</u>   |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>Bethlehem Steel Co.</u>   |                                       | 11. BIRTHPLACE (State or foreign country)<br><u>Delaware N. J.</u>  |                            | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>  |                             |          |  |
| 13. FATHER'S NAME<br><u>William Craig</u>  |                             |   |                                       | 14. MOTHER'S MAIDEN NAME  |                            |  |                             |          |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>no</u>  |                             | 16. SOCIAL SECURITY NO.<br><u>212-07-9470A</u>  |                                       | 17. INFORMANT<br><u>Kathryn Craig (wife)</u><br><u>Records: BCH-4940 Eastern Ave.</u>   |                            | ADDRESS<br><u>same as above</u><br><u>21224</u>  |                             |          |  |
| 18. <u>160.21</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><u>Carcinoma of Rt Maxillary sinus</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                             | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>4 mo</u>   |                                       | (B) DUE TO, OR AS A CONSEQUENCE OF:   |                            | (C) DUE TO, OR AS A CONSEQUENCE OF:  |                             |          |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                             |   |                                       |   |                            |  |                             |          |  |
| 19A. DATE OF OPERATION<br><u>1-23-72</u>   |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                       | 20A. AUTOPSY? (Yes or No)<br><u>NO</u>  |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?   |                             |          |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)   |                                       | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                            |  |                             |          |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                       | 21F. HOW DID INJURY OCCUR?  |                            |  |                             |          |  |
| 22. I certify that (it) (this hospital) attended the deceased from <u>9-3-19 01</u> to <u>1-23-19 02</u> that (I) (we) last saw the deceased alive on <u>1-23-19 72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                             |   |                                       |   |                            |  |                             |          |  |
| 23A. SIGNATURE<br><u>Chu-shin Chiu MD</u>  |                             |   |                                       | Attending Phys. <input checked="" type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input type="checkbox"/> |                            | 23B. DATE SIGNED<br><u>1-23-72</u>   |                             |          |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>CHU-SHIN CHIU</u>   |                             |   |                                       | 23D. ADDRESS<br><u>4940 Eastern Ave. Baltimore, Md. 21224</u><br><u>Baltimore City Hospitals</u>                                |                            |  |                             |          |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                             | 24B. DATE<br><u>1/26/72</u>   |                                       | 24C. NAME OF CEMETERY or CREMATORY<br><u>Gardens of Faith Cemetery</u>  |                            | 24D. LOCATION (City, town, or county) (State)<br><u>Balto. Md.</u>   |                             |          |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>JAN 28 1972</u>  |                             | 25B. NAME OF REGISTRAR<br><u>John E. [unclear]</u>  |                                       | 25C. FUNERAL DIRECTOR<br><u>Schmunek Funeral Homes, Inc.</u>  |                            | ADDRESS<br><u>3331 Brehms Lane, Balto. Md. 21213</u>   |                             |          |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                          |  |                                 |  |  |
|--|--------------------------|--|---------------------------------|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT   |                          | 72 00967   |                                 | REG. NO. 72 00967  |  |
| BIRTH NO. <u>M-532</u>   |                          | 72 00967   |                                 | CERTIFICATE OF DEATH   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>MONDSHOUR, GENEVIEVE CARRIE</u>  |                          | 2. DATE AND HOUR OF DEATH<br><u>JANUARY 26, 1972</u> <u>3:25 P.M.</u>  |                                 |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>ST AGNES HOSPITAL</u><br><u>40 CATON &amp; WILKENS AVE</u>   |                          | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTIMORE</u><br>C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <u>1164 ELM ROAD</u> <u>21227</u> |                                 |  |  |
| 5. SEX <u>FEMALE</u>   | 6. RACE <u>CAUCASIAN</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>   | 8. DATE OF BIRTH <u>9/18/87</u> | 9. AGE (In years last birthday) <u>84</u>  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>   |                          | 10B. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>  |                                 | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>  |  |
| 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>   |                          | 13. FATHER'S NAME <u>JOHN UZELL</u>  |                                 | 14. MOTHER'S MAIDEN NAME <u>MARIE</u>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>   |                          | 16. SOCIAL SECURITY NO. <u>216 05 8271 D</u>   |                                 | 17. INFORMANT <u>BALTIMORE MARYLAND</u> ADDRESS <u>21229 ST AGNES HOSPITAL CATON &amp; WILKENS AVE</u> |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>440.71</u>  |                          | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF: <u>Congestive Heart Failure</u>  |                                 | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>24 HRS</u>   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                          | (B) DUE TO, OR AS A CONSEQUENCE OF: <u>Generalized Arteriosclerosis</u>  |                                 |  |  |
|  |                          | (C) <u>CHRONIC GALL BLADDER &amp; CHOLELITHIASIS</u>   |                                 | <u>4 DAYS</u>  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><u>Isolated Delirium</u>   |                          |  |                                 |  |  |
| 19A. DATE OF OPERATION <u>1-24-72</u>  |                          | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Acute Obstruction AS IN C. ABOVE</u>   |                                 | 20A. AUTOPSY? (Yes or No) <u>NO</u>  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                          | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                                 | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                               |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                          | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |                                 | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (X) (this hospital) attended the deceased from <u>JANUARY 24</u> <u>1972</u> to <u>JANUARY 26</u> <u>1972</u> that (I) (we) last saw the deceased alive on <u>JANUARY 26</u> <u>1972</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (not) view the body after death. |                          |  |                                 |  |  |
| 23A. SIGNATURE <u>Romualdo R. Pator, M.D.</u>  |                          | 23B. DATE SIGNED <u>1-26-72</u>  |                                 | 23C. PHYSICIAN'S NAME (Type) <u>Romualdo R. Pator, M.D.</u>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>   |                          | 24B. DATE <u>1-29-72</u>   |                                 | 24C. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>  |  |
| 24D. LOCATION (City, town, or county) <u>Baltimore, Maryland</u>   |                          | 24E. NAME OF REGISTRAR <u>10000</u>  |                                 | 24F. FUNERAL DIRECTOR <u>130 E. Ft. Ave. Balt., Md. 21230</u>  |  |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 28 1972</u>   |                          | 25B. NAME OF REGISTRAR <u>10000</u>  |                                 | 25C. FUNERAL DIRECTOR <u>130 E. Ft. Ave. Balt., Md. 21230</u>  |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT<br>CERTIFICATE OF DEATH  |  |  |  | REG. NO. <b>72 00968</b>   |
|---|--|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>Margaret Regina Keener</b>  |  | 2. DATE AND HOUR OF DEATH<br><b>1-24-72 2:45 A.M.</b>  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>George Washington N. Home<br/>607 Pennsylvania Ave.</b>   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>md</b> B. COUNTY <b>Baltimore</b> |  |  |
| 5. SEX <b>Female</b> 6. RACE <b>white</b> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <b>12/27/39</b> 9. AGE (in years last birthday) <b>32</b>   |  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Telephone operator</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Telephone Co.</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>             |
| 13. FATHER'S NAME<br><b>Serge Pell</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>Dorothy Pendergast</b>  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  | 16. SOCIAL SECURITY NO.<br><b>212-36-3792</b>  |  | 17. INFORMANT<br><b>Chart.</b>   |
| 18. <b>340X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>MULTIPLE SCLEROSIS</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 yrs.</b>  |  |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____                     |  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |  |  |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>                                 |  | 21F. HOW DID INJURY OCCUR  |
| 22. I certify that (1) (this hospital) attended the deceased from <b>8-2-1921</b> to <b>1-24-1972</b> that (1) (we) last saw the deceased alive on <b>1-23-1972</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (We) (did) (did not) view the body after death. |  |  |  |  |
| 23A. SIGNATURE<br><b>Richard F. Tyson, MD.</b>  |  | 23B. DATE SIGNED<br><b>1-24-72</b>   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>Richard F. Tyson, MD.</b>             |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>1/27/72</b>  |  | 24C. NAME of CEMETERY or CREMATORY<br><b>Oak Lawn Cemetery</b>           |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1972</b>   |  | 25B. NAME OF REGISTRAR<br><b>Richard E. Taylor, MD.</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Prudenzinski Funeral Home</b>                |
|   |  |  |  | ADDRESS<br><b>1407 Eastern Ave.</b>                                      |

ST

ST

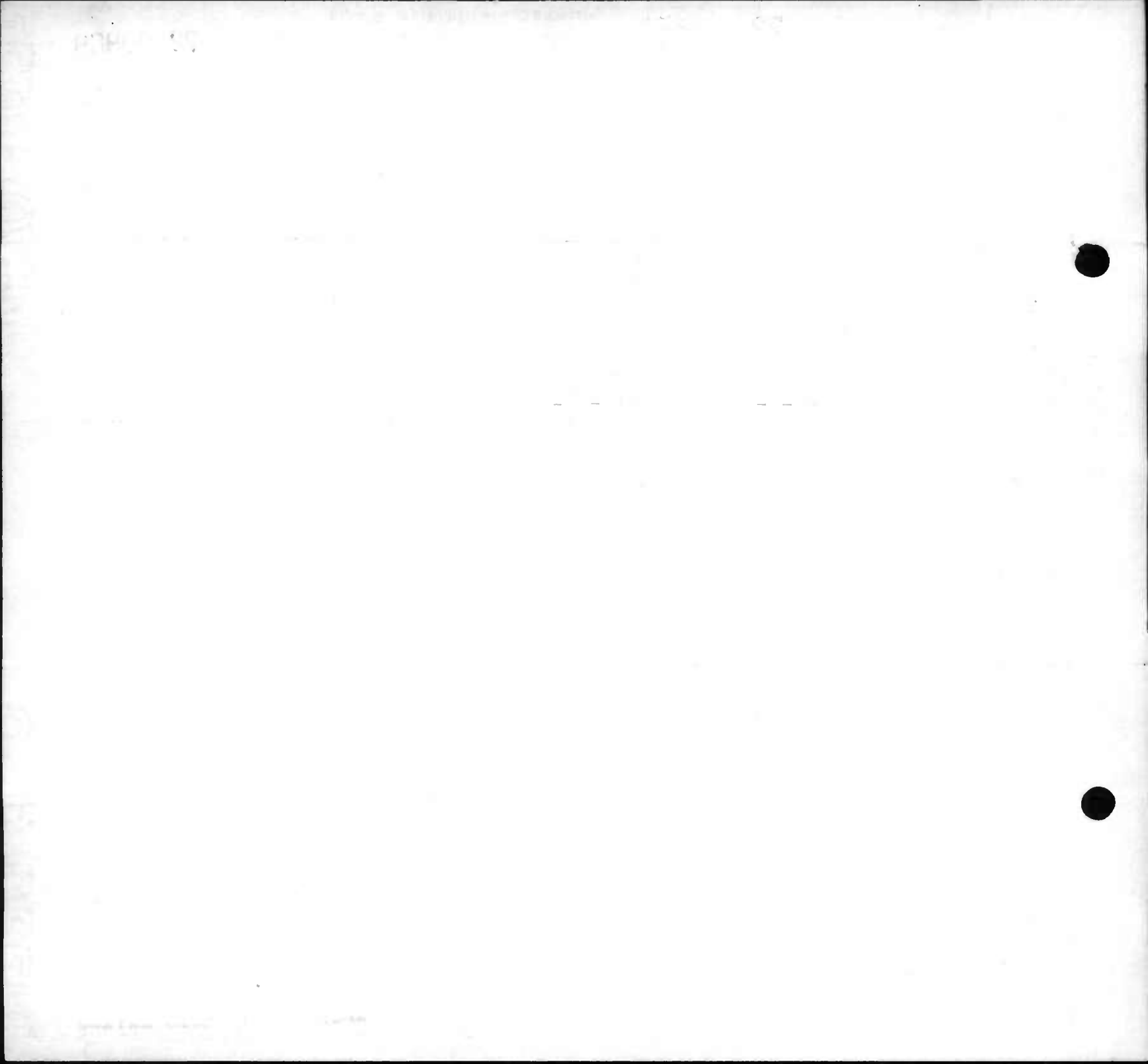
1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

1000 1000 1000 1000 1000 1000 1000 1000 1000 1000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                            |  |  |   |   |
|---|----------------------------|--|--|---|---|
| <div style="display: flex; justify-content: space-between;"> <span><b>6-125</b></span> <span><b>72 00969</b></span> </div>  |                            | <b>BALTIMORE CITY HEALTH DEPARTMENT</b><br><b>CERTIFICATE OF DEATH</b>   |  | <b>REG. NO. 72 00969</b>  |   |
| <b>BIRTH NO.</b><br>1. NAME OF DECEASED<br>(Type or Print) <b>NEKKIE GIBSON</b>   |                            | <b>2. DATE AND HOUR OF DEATH</b><br><b>1-25-72</b> <span style="float: right;"><b>5 a.</b></span>  |  |   |   |
| <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>44 UNION MEMORIAL HOSPITAL</b>   |                            | <b>4. USUAL RESIDENCE</b> (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>MARYLAND</b> B. COUNTY <b>1348</b><br>C. CITY OR TOWN <b>BALTIMORE</b> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>3854 QUARRY AVE</b> |  |   |   |
| <b>5. SEX</b><br><b>F</b>   | <b>6. RACE</b><br><b>W</b> | <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  | <b>8. DATE OF BIRTH</b><br><b>11-16-94</b> | <b>9. AGE</b> (In years last birthday) <b>77</b>  | <b>If Under 1 Yr.</b> Months: Days: <b>If Under 24 Hrs.</b> Hours: Min. |
| <b>10A. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                            | <b>10B. KIND OF BUSINESS OR INDUSTRY</b>   |  | <b>11. BIRTHPLACE</b> (State or foreign country)<br><b>MARYLAND</b>                     |   |
| <b>12. CITIZEN OF WHAT COUNTRY?</b><br><b>AMERICAN</b>  |                            | <b>13. FATHER'S NAME</b><br><b>THOMAS H. FITCH</b>   |  |   |   |
| <b>14. MOTHER'S MAIDEN NAME</b><br><b>ELLA H. BURLINS</b>   |                            | <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |  |   |   |
| <b>16. SOCIAL SECURITY NO.</b><br><b>217-58-5399</b>  |                            | <b>17. INFORMANT</b> <b>EDWIN B. GIBSON</b> ADDRESS <b>SAME</b>  |  |   |   |
| <b>18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>465X1</b>   |                            | <b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE <b>CARDIAC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>UPPER RESPIRATORY INFECTION</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C)  |  |   |   |
| <b>19. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</b>   |                            | <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b>  |  |   |   |
| <b>19A. DATE OF OPERATION</b><br><b>0</b>   |                            | <b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b>  |  | <b>20A. AUTOPSY?</b> (Yes or No)  |   |
| <b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b>   |                            | <b>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (notify medical examiner) <input type="checkbox"/>  |  |   |   |
| <b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)   |                            | <b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)  |  |   |   |
| <b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Approx.)  |                            | <b>21E. INJURY OCCURRED</b> While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | <b>21F. HOW DID INJURY OCCUR?</b>   |   |
| <b>22. I certify that (I) (this hospital) attended the deceased from 1-23 1972 to 1-25 1972 that (I) (we) last saw the deceased alive on 1-24 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b> |                            |  |  |   |   |
| <b>23A. SIGNATURE</b><br><b>Juan M. Calderon</b>  |                            | <b>23B. DATE SIGNED</b><br><b>1-25-72</b>  |  | <b>23C. PHYSICIAN'S NAME</b> (Type) <b>JUAN M. CALDERON M.D.</b>                        |   |
| <b>23D. ADDRESS</b><br><b>UMH</b>   |                            | <b>24A. BURIAL CREMATION, REMOVAL (Specify)</b><br><b>Burial</b>   |  |   |   |
| <b>24B. DATE</b><br><b>1/29/72</b>  |                            | <b>24C. NAME of CEMETERY or CREMATORY</b><br><b>Crest Lawn Gardens</b>   |  | <b>24D. LOCATION</b> (City, town, or county) (State)<br><b>Howard Co., Maryland</b>     |   |
| <b>25A. DATE REC'D BY HEALTH DEPT.</b><br><b>JAN 28 1972</b>  |                            | <b>25B. NAME OF REGISTRAR</b><br><b>Donovan</b>  |  | <b>25C. FUNERAL DIRECTOR</b> <b>Donovan Funeral Home</b> ADDRESS <b>3818 Roland Ave</b> |   |

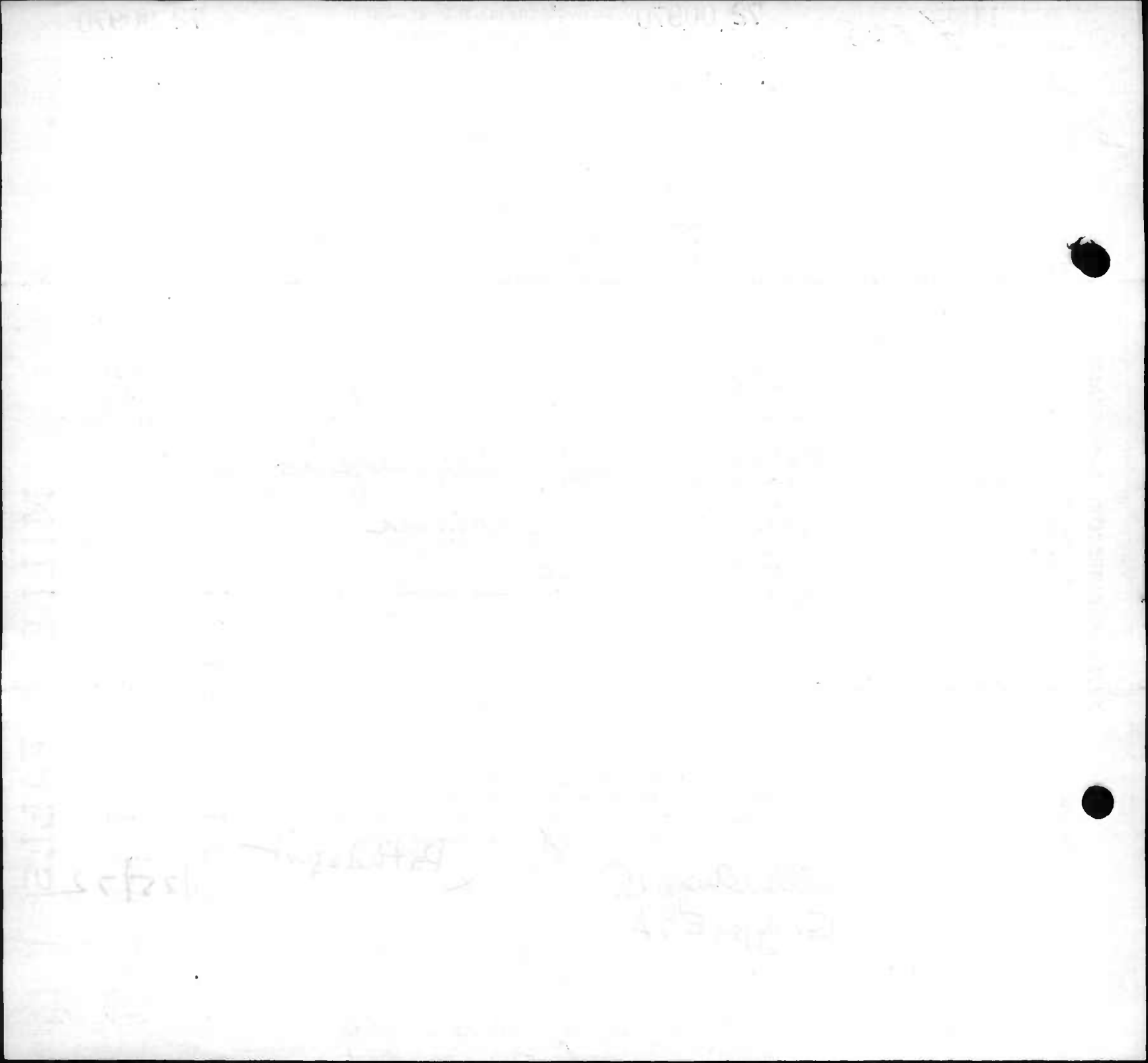




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |
|---|--|--|--|
| <div style="display: flex; justify-content: space-between;"> <span>7-520</span> <span>72 00970</span> <span>BALTIMORE CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>  |  | REG. NO. <span style="font-size: 1.2em;">72 00970</span>   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>Fenwick - Lurean</i>  |  | 2. DATE AND HOUR OF DEATH<br><i>1. 25.78 11.45 P.M.</i>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>S. Baltimore General Hospital</i><br><i>43</i>  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <i>Md.</i><br>B. COUNTY <i>2102</i>   |  |
| 5. SEX <i>Female</i>  |  | 6. RACE <i>white</i>   |  |
| 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 8. DATE OF BIRTH <i>9.23.17</i>  |  |
| 9. AGE (In years last birthday) <i>65</i>   |  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>  |  |
| 11. BIRTHPLACE (State or foreign country) <i>Md.</i>  |  | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>   |  |
| 13. FATHER'S NAME <i>William C. Elliott Dec.</i>  |  | 14. MOTHER'S MAIDEN NAME <i>Ruth, Thompson Dec.</i>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO. <i>217-16-0353-B</i>   |  |
| 17. INFORMANT <i>Husband, Thomas W. Fenwick</i>   |  | ADDRESS <i>Same</i>  |  |
| 18. <i>436.9 I</i><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <i>Chills, sepsis by avert</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) <i>cachexia</i><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <i>CVA</i>  |  |
| 19. DATE OF OPERATION <i>21</i>   |  | 20. AUTOPSY (Yes or No) <i>Yes</i>   |  |
| 21. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> and that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |  |
| 23. SIGNATURE <i>Colleen Griggs MD</i><br>DEGREE  |  | 24. DATE SIGNED <i>1/25/72</i>   |  |
| 25. PHYSICIAN'S NAME (Type) <i>Griggs, E. A.</i><br>DEGREE  |  | 26. ADDRESS <i>McCurly Funeral Home 237 Patapsco Ave 21225</i>   |  |
| 27. BURIAL CREMATION, REMOVAL (Specify) <i>Burial</i>   |  | 28. DATE <i>1/29/72</i>  |  |
| 29. NAME OF CEMETERY OR CREMATORY <i>Our Lady of the Star By the Sea</i>  |  | 30. LOCATION (City, town, or county) (State) <i>Solomons Md.</i>   |  |
| 31. DATE REC'D BY HEALTH DEPT. <i>JAN 28 1972</i>   |  | 32. NAME OF REGISTRAR <i>Robert E. Farley MD</i>   |  |
| 33. FUNERAL DIRECTOR <i>McCurly Funeral Home</i>  |  | 34. ADDRESS <i>237 Patapsco Ave 21225</i>  |  |



# FUNERAL DIRECTOR: IMPORTANT

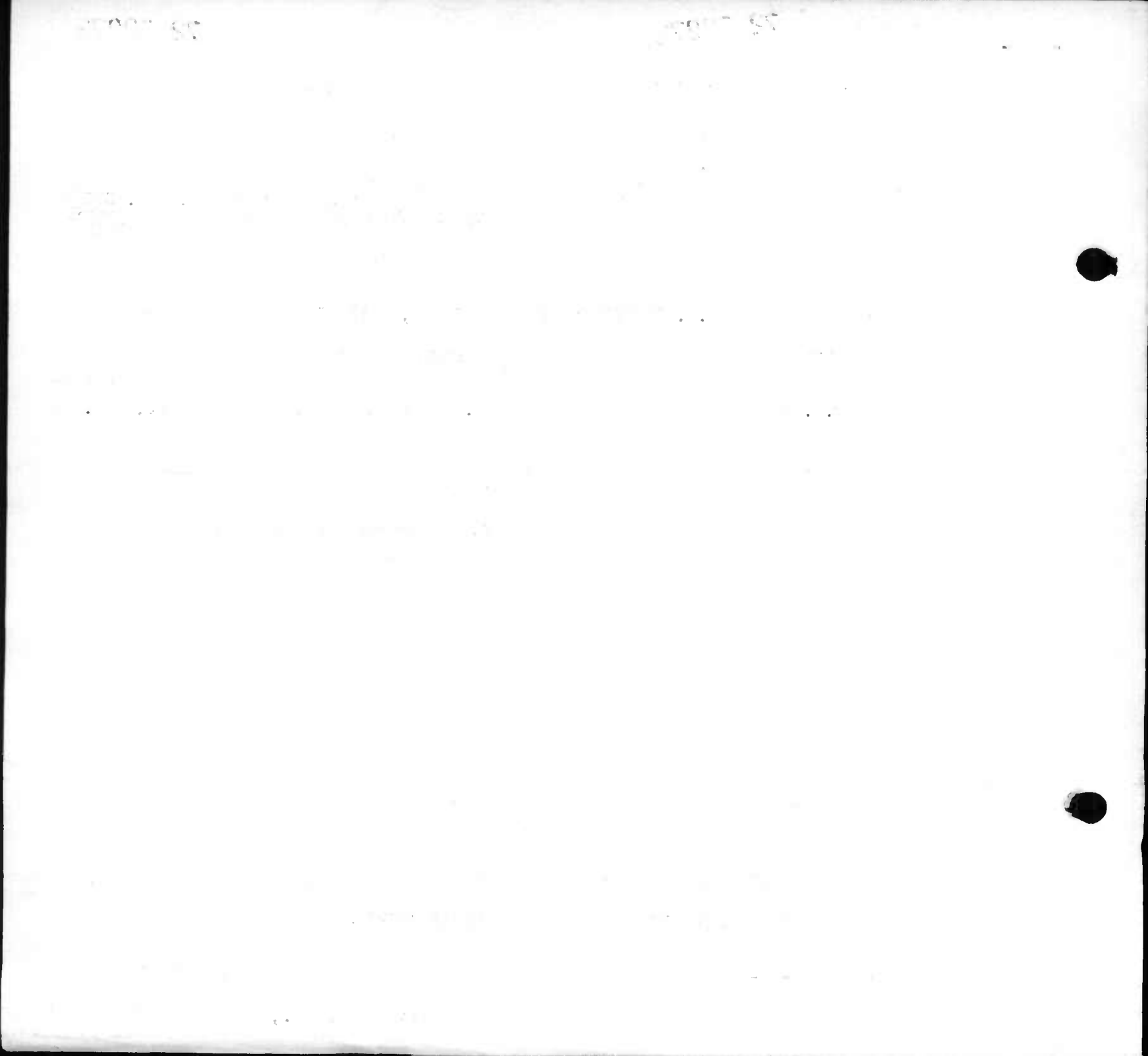
This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |                         |   |  | REG. NO. <b>72 00971</b>                                     |   |
|---|-------------------------|---|--|--|---|
| <b>W-532 72 00971</b><br>BIRTH NO. <i>Carroll Co. Md.</i>   |                         | <b>CERTIFICATE OF DEATH</b>   |  |  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Christopher Wintsch</b>   |                         |   | 2. DATE AND HOUR OF DEATH<br><b>1-26-72 12:20 A.M.</b>   |  |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><br><b>37 Mercy Hospital, Inc.</b>   |                         |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b> B. COUNTY <b>Carroll</b><br>C. CITY OR TOWN <b>Westminster RD#7</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER |  |   |
| 5. SEX<br><b>male</b>   | 6. RACE<br><b>white</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>1-8-72</b>  | 9. AGE (In years last birthday)<br><b>19</b>                 | If Under 1 Yr. Months Days<br>If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>--</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>--</b>  |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b> |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                         |   | 13. FATHER'S NAME<br><b>Alfred William Wintsch, Jr.</b>  |  |   |
| 14. MOTHER'S MAIDEN NAME<br><b>Dorothy Milligent Gasson</b>   |                         |   | 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>--</b>  |  |   |
| 16. SOCIAL SECURITY NO.<br><b>--</b>  |                         | 17. INFORMANT ADDRESS<br><b>Alfred W. Wintsch, Jr. Box 34B Westminster RD#7</b>   |  |  |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>Cardiopulmonary arrest</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Aspiration</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>Intracerebral hemorrhage 17 days</b><br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>6 hrs</b> |                         |   | 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b>  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                         |   |  |  |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>No</b>                       |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                         | 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)                     |  |  |   |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                         | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>White At <input type="checkbox"/> Not White At <input type="checkbox"/> Work  |  | 21F. HOW DID INJURY OCCUR?                                   |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>Jan. 18</b> 19 <b>72</b> to <b>Jan. 26</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>Jan. 26</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) ( <del>not</del> ) view the body after death.   |                         |   |  |  |   |
| 23A. SIGNATURE<br><i>Y H Lim</i>  |                         |   | 23B. DATE SIGNED<br><b>1/26/72</b>   |  | 23C. PHYSICIAN'S NAME (Type)<br><b>Young Hei Lim</b>      |
| 23D. ADDRESS<br><b>Mercy Hospital</b>   |                         |   | 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>burial</b>  |  |   |
| 24B. DATE<br><b>1/27/72</b>   |                         |   | 24C. NAME of CEMETERY or CREMATORY<br><b>Meadow Branch Cemetery</b>  |  |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>nr Westminster, Carroll, Md.</b>  |                         |   | 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 28 1972</b>  |  |   |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Z...</b>   |                         |   | 25C. FUNERAL DIRECTOR<br><b>Robert E. Z...</b>   |  |   |
| 25D. ADDRESS<br><b>95 Willis St. Hagerstown, Md.</b>  |                         |   |  |  |   |

18710 55

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT  |   |  |   | REG. NO. <span style="font-size: 1.2em;">72 00972</span>   |  |
|---|---|--|---|--|--|
| <div style="display: flex; justify-content: space-between;"> <span style="font-size: 1.5em;">L-150</span> <span style="font-size: 1.5em;">72 00972</span> </div> <div style="text-align: center; font-weight: bold; font-size: 1.2em;">CERTIFICATE OF DEATH</div>   |   |  |   |  |  |
| BIRTH NO.   |   | 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">FRANK LEVIN</span>  |   |  |  |
| 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">1-25-72</span> <span style="float: right;">950 A.M.</span>   |   | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |   |  |  |
| 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <span style="font-size: 1.2em;">MARYLAND</span><br>B. COUNTY <span style="font-size: 1.2em;">1301</span>  |   | FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)<br><span style="font-size: 1.2em;">SINAI HOSPITAL OF BALTIMORE</span><br><span style="font-size: 1.5em;">42</span>                               |   |  |  |
| C. CITY OR TOWN<br><span style="font-size: 1.2em;">BALTIMORE</span>   |   | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/>   |   |  |  |
| E. STREET AND NUMBER<br><span style="font-size: 1.2em;">2525 EUTAW PLACE, APT. 3 I</span><br><span style="font-size: 1.2em;">XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX</span>  |   |  |   |  |  |
| 5. SEX<br><span style="font-size: 1.2em;">MALE</span>   | 6. RACE<br><span style="font-size: 1.2em;">WHITE</span> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  | 8. DATE OF BIRTH<br><span style="font-size: 1.2em;">12-25-96</span> | 9. AGE (In years last birthday)<br><span style="font-size: 1.2em;">75</span>                                     | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><span style="font-size: 1.2em;">CHAUFFEUR</span> |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><span style="font-size: 1.2em;">U.S. POSTAL SERVICE</span>  |   | 11. BIRTHPLACE (State or foreign country)<br><span style="font-size: 1.2em;">CHICAGO, ILLINOIS</span>            |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><span style="font-size: 1.2em;">USA</span>  |   | 13. FATHER'S NAME<br><span style="font-size: 1.2em;">NATHAN LEVIN</span>   |   | 14. MOTHER'S MAIDEN NAME<br><span style="font-size: 1.2em;">RACHEL ?</span>                                      |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>YES <input checked="" type="checkbox"/> W.W. I  |   | 16. SOCIAL SECURITY NO.  |   | 17. INFORMANT<br><span style="font-size: 1.2em;">MRS. BEATRICE LEVIN, 2525 EUTAW PL, APT. 3I</span>              |  |
| 18. <span style="font-size: 1.5em;">436.9 I</span><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE <span style="font-size: 1.2em;">PNEUMONIA</span><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) <span style="font-size: 1.2em;">CEREBRAL VASCULAR ACCIDENT</span><br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) _____ |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |   |  |   |  |  |
| 19A. DATE OF OPERATION<br><span style="font-size: 1.2em;">0</span>  |   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |   | 20A. AUTOPSY? (Yes or No)  |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |   |  |   |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |   | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <span style="font-size: 1.2em;">1-19</span> 19 <span style="font-size: 1.2em;">72</span> to <span style="font-size: 1.2em;">1-25</span> 19 <span style="font-size: 1.2em;">72</span> that (I) (we) last saw the deceased alive on <span style="font-size: 1.2em;">1-25</span> 19 <span style="font-size: 1.2em;">72</span> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |   |  |   |  |  |
| 23A. SIGNATURE<br><span style="font-size: 1.2em;">Susan Macht Cohen MD</span>   |   | 23B. DATE SIGNED<br><span style="font-size: 1.2em;">1-25-72</span>   |   | 23C. PHYSICIAN'S NAME (Type)<br><span style="font-size: 1.2em;">SUSAN MACHT COHEN</span>                         |  |
| 23D. ADDRESS<br><span style="font-size: 1.2em;">SINAI HOSPITAL</span>   |   |  |   |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><span style="font-size: 1.2em;">BURIAL</span>   |   | 24B. DATE<br><span style="font-size: 1.2em;">1-26-72</span>  |   | 24C. NAME OF CEMETERY OR CREMATORY<br><span style="font-size: 1.2em;">SHAAREI TFILOH</span>                      |  |
| 24D. LOCATION (City, town, or county) (State)<br><span style="font-size: 1.2em;">BALTIMORE, MARYLAND</span>   |   |  |   |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><span style="font-size: 1.2em;">JAN 31 1972</span>   |   | 25B. NAME OF REGISTRAR<br><span style="font-size: 1.2em;">[Signature]</span>   |   | 25C. FUNERAL DIRECTOR<br><span style="font-size: 1.2em;">SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</span> |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |  |  |
|---|--|--|--|--|--|
| <p style="font-size: 24pt; margin: 0;">M-460</p> <p style="font-size: 24pt; margin: 0;">72 00973</p>  |  | <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>CERTIFICATE OF DEATH</b></p>   |  | <p>REG. NO. <span style="font-size: 24pt;">72 00973</span></p>   |  |
| <p>BIRTH NO. _____</p>  |  | <p>1. NAME OF DECEASED<br/>(Type or Print) <u>REBECCA MILLER</u></p>   |  | <p>2. DATE AND HOUR OF DEATH<br/><u>1/25/72</u> <u>1:30 P. M.</u></p>  |  |
| <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p> <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br/><u>SINAI HOSPITAL OF BALTIMORE</u></p>   |  | <p>4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br/>A. STATE <u>MARYLAND</u> B. COUNTY <u>BALTO</u></p>   |  | <p>C. CITY OR TOWN <u>BALTIMORE</u> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> |  |
| <p>5. SEX <u>FEMALE</u> 6. RACE <u>WHITE</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></p>  |  | <p>8. DATE OF BIRTH <u>04/15/95</u> 9. AGE (In years last birthday) <u>76</u></p>  |  | <p>10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u></p>                 |  |
| <p>11. BIRTHPLACE (State or foreign country) <u>RUSSIA</u></p>  |  | <p>12. CITIZEN OF WHAT COUNTRY? <u>USA</u></p>   |  | <p>13. FATHER'S NAME <u>SHOLOM BARR</u></p>  |  |
| <p>14. MOTHER'S MAIDEN NAME <u>UNKNOWN</u></p>  |  | <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>NO</u></p>  |  | <p>16. SOCIAL SECURITY NO. _____</p>   |  |
| <p>17. INFORMANT <u>MRS. ROSE LEVITAS, 3302 KENJAC ROAD, #21207</u></p>   |  | <p>18. <u>436.9 I</u> CAUSE OF DEATH</p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> |  | <p>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br/><u>Days</u></p>  |  |
| <p>19. DATE OF OPERATION <u>0</u></p>   |  | <p>20A. AUTOPSY? (Yes or No) <u>NO</u></p>   |  | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>  |  |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/></p>   |  | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)</p>   |  | <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>  |  |
| <p>21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)</p>  |  | <p>21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>  |  | <p>21F. HOW DID INJURY OCCUR?</p>  |  |
| <p>22. I certify that <u>(X)</u> (this hospital) attended the deceased from <u>01/21</u> 19 <u>72</u> to <u>1/25</u> 19 <u>72</u> that <u>(X)</u> (we) last saw the deceased alive on <u>1/25</u> 19 <u>72</u> and that in <u>(my)</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>(X)</u> (We) (did) (did not) view the body after death.</p> |  |  |  |  |  |
| <p>23A. SIGNATURE <u>B. Kerzner MA</u></p>  |  | <p>23B. DATE SIGNED <u>1/25/72</u></p>   |  | <p>23C. PHYSICIAN'S NAME (Type) <u>B. KERZNER</u></p>  |  |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify) <u>BURIAL</u></p>   |  | <p>24B. DATE <u>1-26-72</u></p>  |  | <p>24C. NAME OF CEMETERY or CREMATORY <u>BNAI ISRAEL</u></p>   |  |
| <p>24D. LOCATION (City, town, or county) <u>BALTIMORE, MARYLAND</u></p>   |  | <p>24E. ADDRESS <u>SINAI HOSPITAL</u></p>  |  | <p>25A. DATE REC'D BY HEALTH DEPT. <u>JAN 31 1972</u></p>  |  |
| <p>25B. NAME OF REGISTRAR <u>Urbel E. ...</u></p>   |  | <p>25C. FUNERAL DIRECTOR <u>SQL LEVINSON &amp; BROS.</u></p>   |  | <p>ADDRESS <u>6010 REISTERSTOWN ROAD</u></p>   |  |

2500

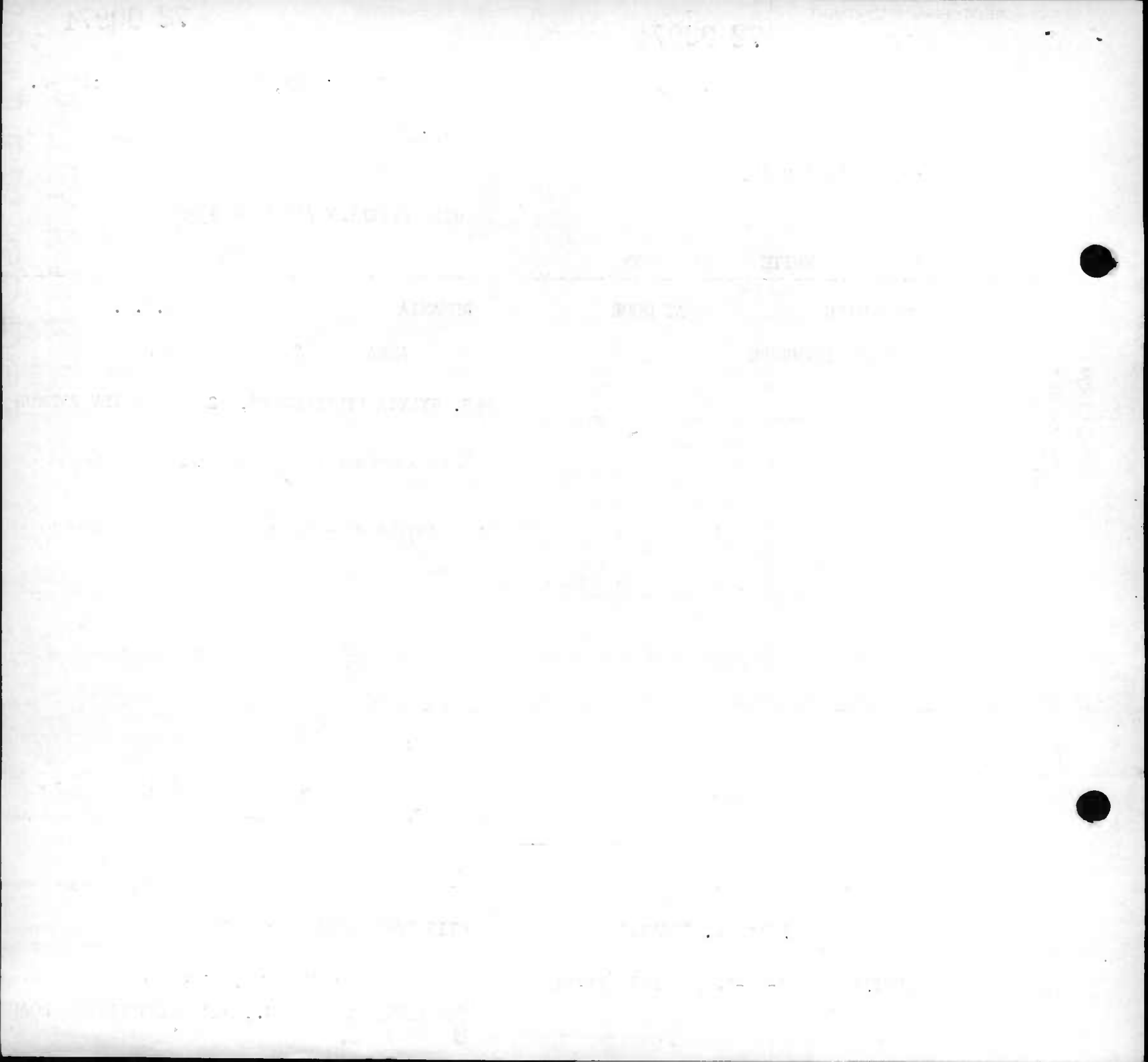
1957



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

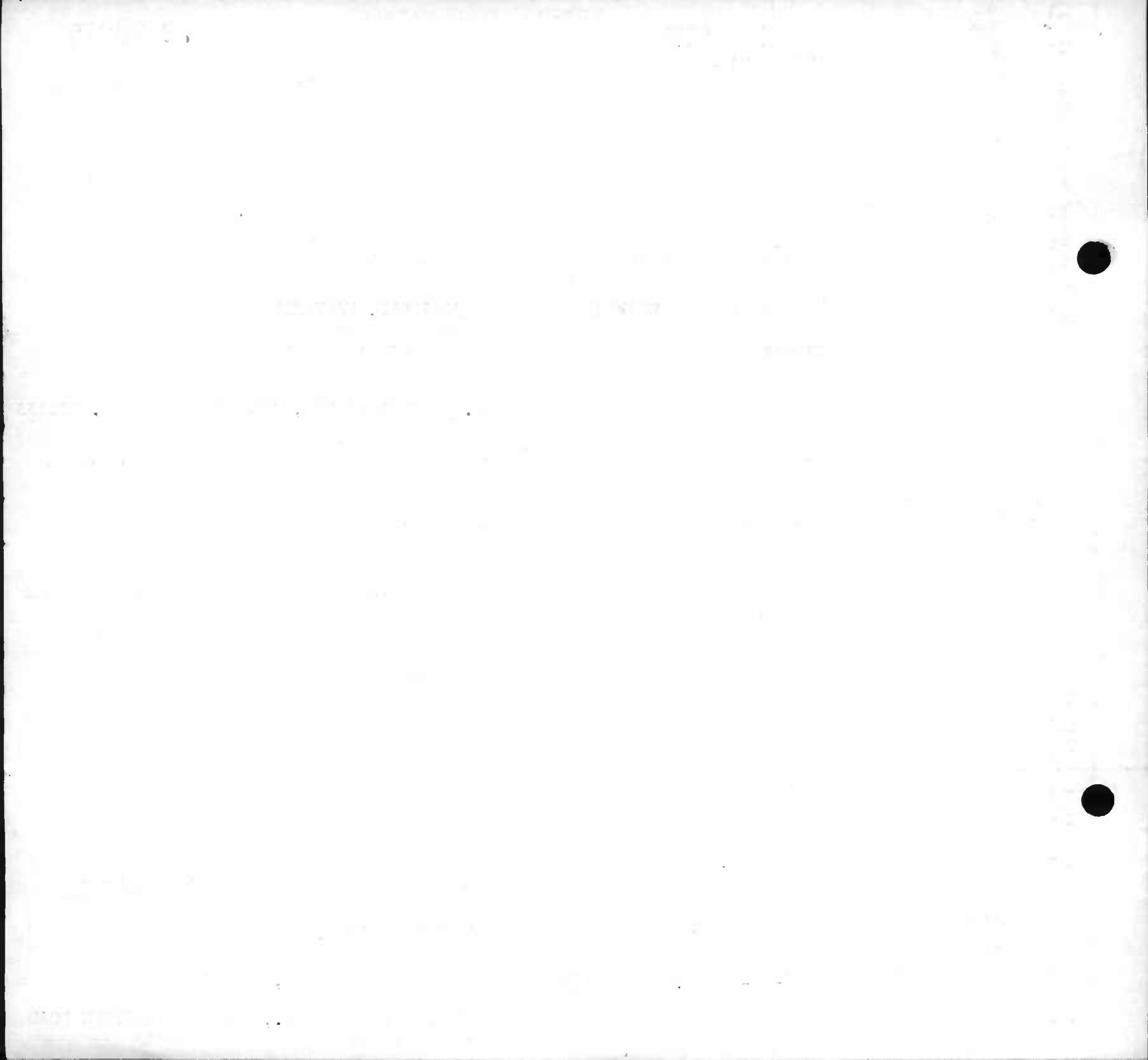
| S-455   |                  | 72 00974  |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | 72 00974   |  |
|---|------------------|---|--|--|--|--|--|
| BIRTH NO.   |                  | 72 00974  |  | CERTIFICATE OF DEATH   |  | REG. NO.   |  |
| 1. NAME OF DECEASED<br>(Type or Print)  |                  |   |  | 2. DATE AND HOUR OF DEATH  |  |  |  |
| ESTHER SOLOMON  |                  |   |  | JANUARY 25, 1972   |  | 8:15 A.M.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)  |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>6230 BERKELEY AVENUE<br><br>00  |                  |   |  | A. STATE<br>MARYLAND   |  |  |  |
|   |                  |   |  | C. CITY OR TOWN<br>BALTIMORE   |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |  |
|   |                  |   |  | E. STREET AND NUMBER<br>6230 BERKELEY AVENUE #21209  |  |  |  |
| 5. SEX<br>FEMALE  | 6. RACE<br>WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH   |  | 9. AGE (In years lost birthday)<br>92  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE  |                  | 10B. KIND OF BUSINESS OR INDUSTRY<br>AT HOME  |  | 11. BIRTHPLACE (State or foreign country)<br>RUMANIA   |  | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A.   |  |
| 13. FATHER'S NAME<br>MORRIS EISENBERG   |                  |   |  | 14. MOTHER'S MAIDEN NAME<br>ANNA ?   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO  |                  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br>MRS. SYLVIA FINKELSTEIN, 6230 BERKELEY AVENUE   |  |  |  |
| 18. 436.01<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |   |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>Cerebrovascular accident<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) Essential hypertension<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>3 days<br><br>15 years             |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                  |   |  |  |  |  |  |
| 19A. DATE OF OPERATION  |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?               |  |
| 0   |                  |   |  |  |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |  |  |
| 21D. TIME OF INJURY (APPROX.)   |                  | 21E. INJURY OCCURRED  |  | 21F. HOW DID INJURY OCCUR?   |  |  |  |
|   |                  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  |  |  |  |  |
| 22. I certify that (I) (the hospital) attended the deceased from 1960 to 1/25 1972, that (I) (we) last saw the deceased alive on 1/21 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                  |   |  |  |  |  |  |
| 23A. SIGNATURE<br>Sheldon C. Kravitz, M.D.  |                  |   |  | 23B. DATE SIGNED<br>1-25-72  |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br>SHELDON C. KRAVITZ  |                  |   |  | 23D. ADDRESS<br>6715 PARK HEIGHTS AVENUE   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL  |                  |   |  | 24B. DATE<br>1-26-72   |  | 24C. NAME OF CEMETERY or CREMATORY<br>BNAI ISRAEL                                  |  |
| 24D. LOCATION<br>BALTIMORE, MARYLAND  |                  |   |  |  |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>JAN 31 1972  |                  |   |  | 25B. NAME OF REGISTRAR<br>Robert E. Jaber, M.D.  |  | 25C. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD              |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |  |   |  | REG. NO. <span style="font-size: 2em;">72 00975</span>  |  |
|--|--|---|--|---|--|
| <b>U-414</b><br><b>72 00975</b><br><b>CERTIFICATE OF DEATH</b>   |  | <b>1. NAME OF DECEASED</b><br>(Type or Print) <span style="font-size: 1.5em;">Anna Unlfelder</span>   |  |   |  |
| <b>2. DATE AND HOUR OF DEATH</b><br><span style="font-size: 1.5em;">1-25-72</span> <span style="font-size: 1.5em;">12 17 A M.</span>   |  | <b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><span style="font-size: 1.5em;">Sinai Hospital of Balto. Baltimore, Md. 21215</span>  |  |   |  |
| <b>4. USUAL RESIDENCE</b> (Where deceased lived, If institution: residence before admission)<br>A. STATE <span style="font-size: 1.5em;">Md.</span> B. COUNTY <span style="font-size: 1.5em;">Baltimore</span>   |  | <b>5. CITY OR TOWN</b> <span style="font-size: 1.5em;">Randallstown</span> <b>D. INSIDE CITY LIMITS?</b><br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>   |  |   |  |
| <b>6. STREET AND NUMBER</b><br><span style="font-size: 1.5em;">4006 Starbrook Rd.</span>   |  | <b>5. SEX</b> <span style="font-size: 1.5em;">Female</span> <b>6. RACE</b> <span style="font-size: 1.5em;">White</span> <b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br><b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/> |  |   |  |
| <b>8. DATE OF BIRTH</b> <span style="font-size: 1.5em;">3-5-96</span> <b>9. AGE</b> (In years last birthday) <span style="font-size: 1.5em;">75</span>   |  | <b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.5em;">Housewife</span> <b>10B. KIND OF BUSINESS OR INDUSTRY</b> <span style="font-size: 1.5em;">AT HOME</span>  |  |   |  |
| <b>11. BIRTHPLACE</b> (State or foreign country) <span style="font-size: 1.5em;">BALTIMORE, MARYLAND</span>  |  | <b>12. CITIZEN OF WHAT COUNTRY?</b> <span style="font-size: 1.5em;">USA</span>  |  |   |  |
| <b>13. FATHER'S NAME</b><br><span style="font-size: 1.5em;">JOSEPH BERKOW</span>   |  | <b>14. MOTHER'S MAIDEN NAME</b><br><span style="font-size: 1.5em;">MINNIE ?</span>  |  |   |  |
| <b>15. Was Deceased Ever in U. S. Armed Forces?</b> (Yes, no or unknown) (If yes, give war or dates of service)<br><span style="font-size: 1.5em;">NO</span>   |  | <b>16. SOCIAL SECURITY NO.</b>  |  | <b>17. INFORMANT</b> <span style="font-size: 1.5em;">MRS. DOROTHY KANTER, 4006 STARBROOK RD. #21133</span> <b>ADDRESS</b> |  |
| <b>18. CAUSE OF DEATH</b><br><div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b><br/>                     (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br/> <b>ANTECEDENT CAUSES</b><br/>                     DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br/> <div style="text-align: center; font-weight: bold;">II</div> <b>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</b> </div> <div style="width: 35%;"> <b>(A) IMMEDIATE CAUSE</b><br/>                     DUE TO, OR AS A CONSEQUENCE OF:<br/> <span style="font-size: 1.5em;">Acute pulmonary edema</span><br/> <b>(B)</b><br/>                     DUE TO, OR AS A CONSEQUENCE OF:<br/> <span style="font-size: 1.5em;">ASHD</span><br/> <b>(C)</b> </div> <div style="width: 5%;"> <b>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH</b><br/> <span style="font-size: 1.5em;">1 hour</span> </div> </div> |  |   |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

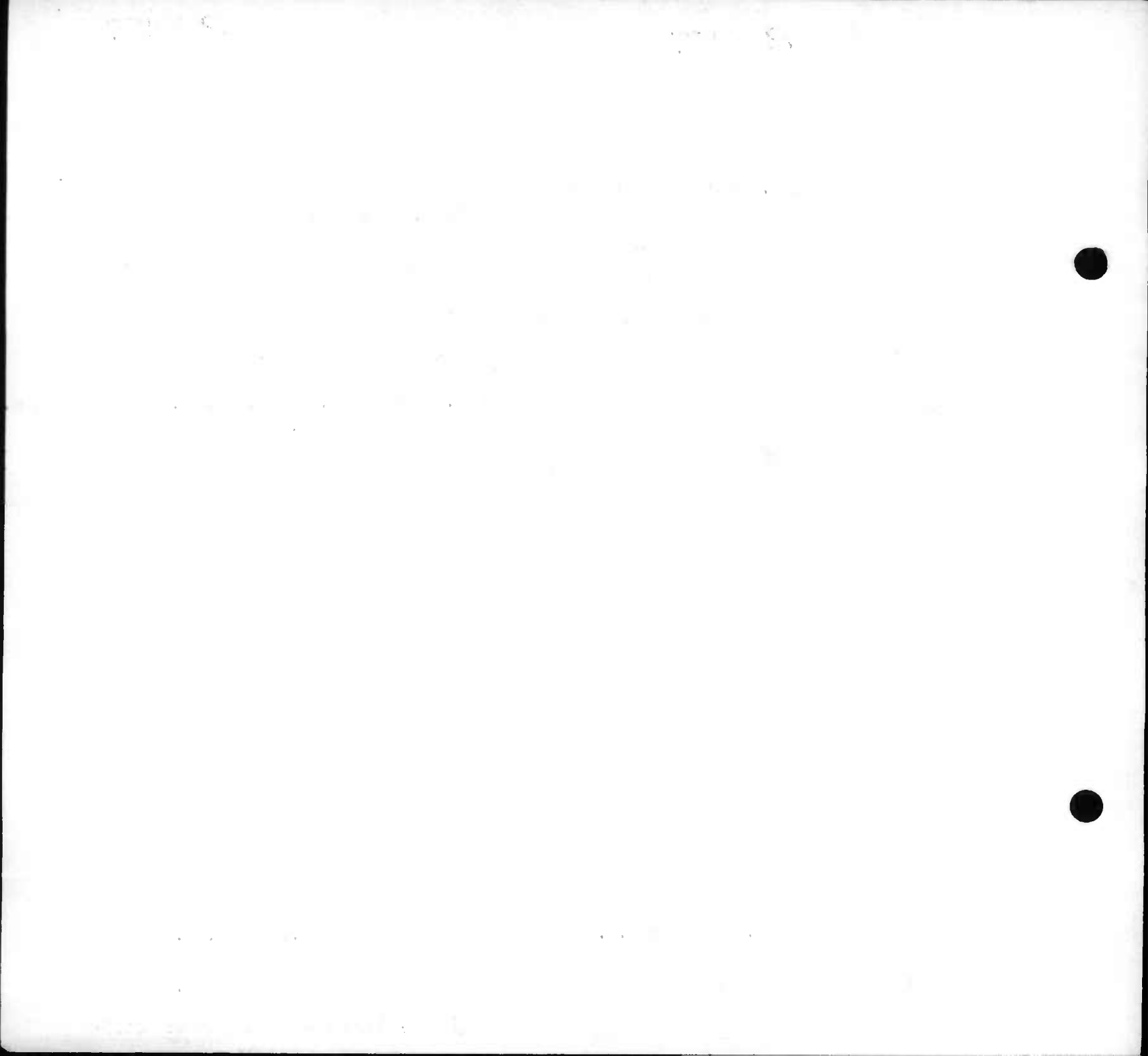
|  |                     |   |                                    |  |                            |   |  |
|--|---------------------|---|------------------------------------|--|----------------------------|---|--|
| C-155  |                     | 72 00976  |                                    | BALTIMORE CITY HEALTH DEPARTMENT   |                            | REG. NO. 72 00976   |  |
| BIRTH NO.  |                     |   |                                    | CERTIFICATE OF DEATH   |                            |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <i>CHAPMAN ANNA</i>   |                     |   |                                    | 2. DATE AND HOUR OF DEATH<br><i>11/29/72 at 7:15 a. M.</i>   |                            |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><i>LUTHERN HOSPITAL</i><br><i>46</i>  |                     |   |                                    | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <i>DURELAND</i> B. COUNTY <i>Nursing Home</i><br>C. CITY OR TOWN <i>Baltimore</i> D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <i>1607</i> |                            |   |  |
| 5. SEX<br><i>F</i>   | 6. RACE<br><i>N</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><i>1-11-87</i> | 9. AGE (In years last birthday)<br><i>85</i>   | 10. Under 1 To Months Days | 11. Under 24 Hrs. Hours Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><i>Retired</i>  |                     |   |                                    | 10B. KIND OF BUSINESS OR INDUSTRY  |                            | 11. BIRTHPLACE (State or foreign country)<br><i>Virginia</i>          |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><i>U.S.A.</i>  |                     |   |                                    |  |                            |   |  |
| 13. FATHER'S NAME<br><i>Charles F. Reid</i>  |                     |   |                                    | 14. MOTHER'S MAIDEN NAME<br><i>Mary E. Carver</i>  |                            |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |                     |   |                                    | 16. SOCIAL SECURITY NO.  |                            | 17. INFORMANT<br><i>Charles F. Reid, Balto, Md.</i>                   |  |
| 18. <i>727.01</i> DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><i>Congestive Cardiac Failure</i>  |                     |   |                                    | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |                            |   |  |
| 1. This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.  |                     |   |                                    | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:   |                            |   |  |
| 2. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                     |   |                                    | (B) DUE TO, OR AS A CONSEQUENCE OF:  |                            |   |  |
| (C)  |                     |   |                                    |  |                            |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                     |   |                                    |  |                            |   |  |
| 19A. DATE OF OPERATION<br><i>0</i>   |                     | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                    | 20A. AUTOPSY? (Yes or No)<br><i>NO</i>   |                            | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                     | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)   |                                    | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                            |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                     | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                    | 21F. HOW DID INJURY OCCUR?   |                            |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>19</i> that (I) (we) last saw the deceased alive on <i>19</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                     |   |                                    |  |                            |   |  |
| 23A. SIGNATURE<br><i>Anyana Dosh M.D.</i>  |                     |   |                                    | 23B. DATE SIGNED   |                            |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><i>ANYANA DOSH M.D.</i>  |                     |   |                                    | 23D. ADDRESS   |                            |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><i>Burial</i>  |                     | 24B. DATE<br><i>2-2-1972</i>  |                                    | 24C. NAME OF CEMETERY or CREMATORY<br><i>Bremer Hall</i>   |                            | 24D. LOCATION (City, town, or county) (State)<br><i>Annapolis Md.</i> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><i>JAN 31 1972</i>  |                     | 25B. NAME OF REGISTRAR<br><i>Robert E. ...</i>  |                                    | 25C. FUNERAL DIRECTOR<br><i>William Beebe ...</i>  |                            | 25D. ADDRESS  |  |

12/11/70 Adm. to N.H.  
came from another N.H.

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| G-140   |                         | 72 00977  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | 72 00977  |                               |
|---|-------------------------|---|--|---|--|---|-------------------------------|
| BIRTH NO.   |                         |   |  | REG. NO.  |  |   |                               |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Earl William Gable</b>   |                         |   |  | 2. DATE AND HOUR OF DEATH<br><b>1/28/72</b>   |  |   |                               |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>00 302 S. Beechfield Avenue</b>   |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <b>Md</b><br>B. COUNTY <b>2531</b> |  |   |                               |
|   |                         |   |  | C. CITY OR TOWN<br><b>Baltimore</b>   |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |                               |
|   |                         |   |  | E. STREET AND NUMBER<br><b>302 S. Beechfield Avenue</b>   |  |   |                               |
| 5. SEX<br><b>male</b>   | 6. RACE<br><b>white</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>12/13/09</b>   | 9. AGE (In years last birthday)<br><b>62</b> | 10. Under 1 Yr. Months: Days:   | 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>retired policeman</b>   |                         |   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Balto City Police</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>                                  |                               |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |                         |   |  |   |  |   |                               |
| 13. FATHER'S NAME<br><b>Guy Gable (late)</b>  |                         |   |  | 14. MOTHER'S MAIDEN NAME<br><b>Ella Feldmeyer (Late)</b>  |  |   |                               |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>no</b>   |                         |   |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT<br><b>Mrs. Margaret V. Gable, 302 S. Beechfield Ave.</b>                        |                               |
| 18. CAUSE OF DEATH<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oslhenia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>410.9 I</b><br><b>Coronary Heart Disease</b><br><b>8 yrs</b> |                         |   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |   |                               |
| MEDICAL CERTIFICATION   |                         |   |  |   |  |   |                               |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                         |   |  |   |  |   |                               |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?                          |                               |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |   |                               |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |   |                               |
| 22. I certify that (I) (this hospital) attended the deceased from <b>January 1953</b> to <b>January 1972</b> that (I) (we) last saw the deceased alive on <b>1/26/72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.   |                         |   |  |   |  |   |                               |
| 23A. SIGNATURE<br><b>Aloha H. Crowther M.D.</b>   |                         |   |  | 23B. DATE SIGNED<br><b>1/30/72</b>  |  |   |                               |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Aloha H. Crowther M.D.</b>   |                         |   |  | 23D. ADDRESS<br><b>4209 Frederick Ave., Balto. Md.</b>  |  |   |                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>1/31/72</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Crestlawn Cemetery</b>   |  | 24D. LOCATION (City, town, or county) (State)<br><b>Marriottsville, Md.</b>                   |                               |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 31 1972</b>   |                         | 25B. NAME OF REGISTRAR<br><b>Robert J. ...</b>  |  | 25C. FUNERAL DIRECTOR<br><b>Witzke, 1635 Edmondson Avenue 21228</b>   |  | ADDRESS   |                               |

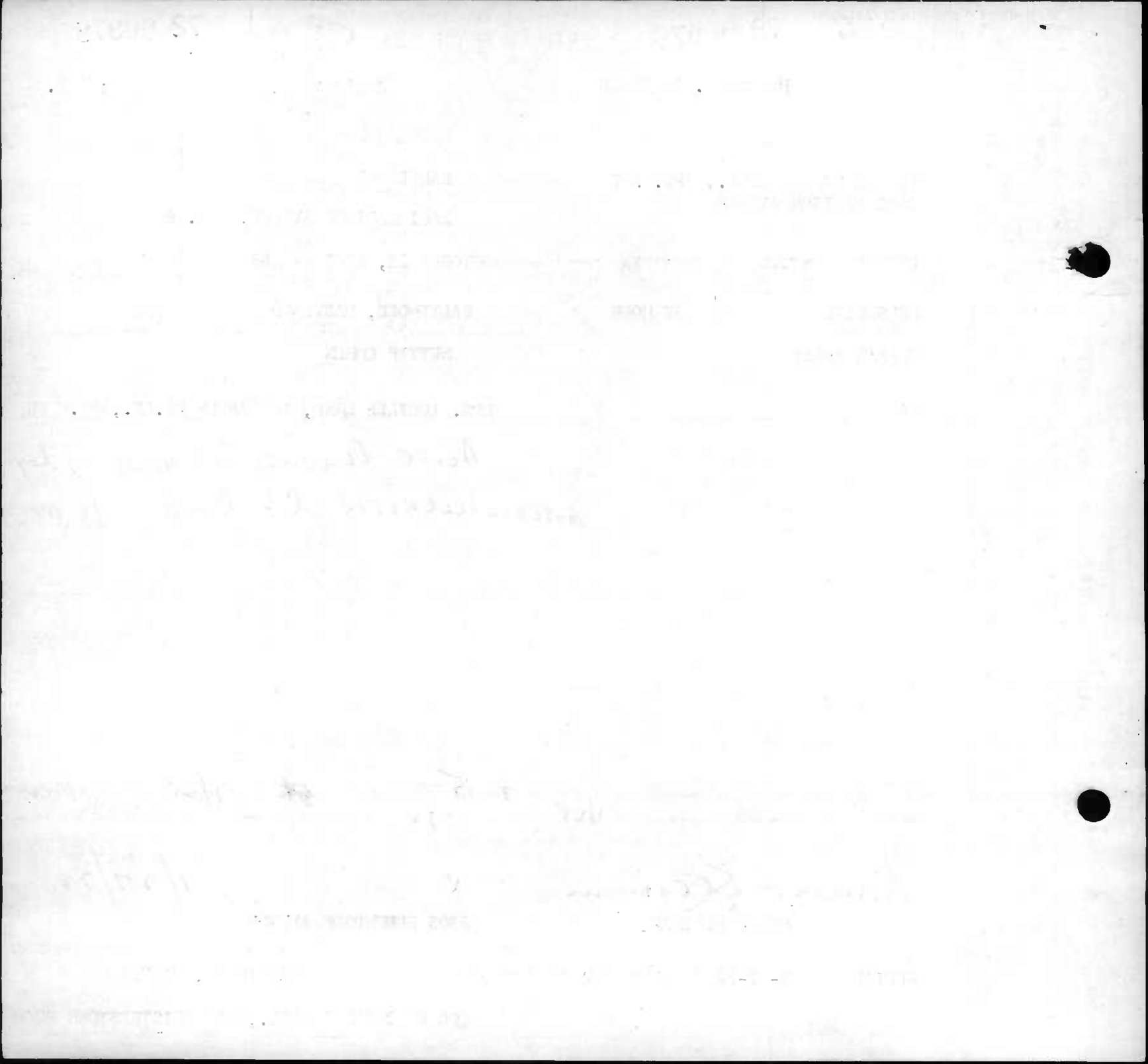




# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                         |   |  | REG. NO. <b>72 00978</b>   |  |
|--|-------------------------|---|--|--|--|
| B-262 72 00978   |                         |   |  | CERTIFICATE OF DEATH   |  |
| BIRTH NO.  |                         |   |  | 2  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>THERESA A. BACHRACH</b>  |                         |   |  | 2. DATE AND HOUR OF DEATH<br><b>JANUARY 25, 1972 5:30 P. M.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                         |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>TEMPLE GARDEN APTS., APT. 607<br/>2601 MADISON AVENUE</b>  |                         |   |  | A. STATE <b>MARYLAND</b><br>C. CITY OR TOWN <b>BALTIMORE</b><br>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <b>2601 MADISON AVENUE, APT. 607</b> |  |
| 5. SEX<br><b>FEMALE</b>  | 6. RACE<br><b>WHITE</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>OCTOBER 23, 1887 84</b> | 9. AGE (In years last birthday)  | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>HOUSEWIFE</b>  |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>AT HOME</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MARYLAND</b>  |  |
| 13. FATHER'S NAME<br><b>HERMAN ADLER</b>   |                         |   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |                         |   |  | 14. MOTHER'S MAIDEN NAME<br><b>NETTIE COHEN</b>  |  |
| 16. SOCIAL SECURITY NO.  |                         |   |  | 17. INFORMANT ADDRESS<br><b>MRS. LUCILLE LAND, 19 WARREN PK. DR., APT. C #8</b>  |  |
| 18. <b>410.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoporosis, etc. It means the disease, injury or complication which caused death.)<br><b>ACUTE CORONARY THROMBOSIS 1 day</b><br><b>ARTERIO SCLEROTIC C.V. Disease 10 yrs.</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A). |                         |   |  | CAUSE OF DEATH<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |
| 19A. DATE OF OPERATION   |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>7-15</b> 19 <b>54</b> to <b>1/25</b> 19 <b>72</b> , that (I) (we) last saw the deceased alive on <b>1/25</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                         |   |  |  |  |
| 23A. SIGNATURE<br><b>Norman K. Kleiman</b>   |                         |   |  | 23B. DATE SIGNED<br><b>1/27/72</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>NORMAN KLEIMAN</b>  |                         |   |  | 23D. ADDRESS<br><b>3803 EDMONDSON AVENUE</b>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |                         | 24B. DATE<br><b>1-27-72</b>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>OHEB SHALOM</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 31 1972</b>  |                         | 25B. NAME OF REGISTRAR<br><b>Robert E. Fisher</b>   |  | 25C. FUNERAL DIRECTOR ADDRESS<br><b>OLD DEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>   |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| W-516  |                      | 72 00979  |  | BALTIMORE CITY HEALTH DEPARTMENT  |   | X REG. NO. 72 00979   |  |
|--|----------------------|---|--|---|---|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <u>Weinberg, Harry</u>  |                      |   |  | 2. DATE AND HOUR OF DEATH<br><u>1-26-72</u> <u>12</u> <sup>10</sup> <u>A.</u> M.  |   |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><u>North Charles General Hospital</u>   |                      |   |  | 4. USUAL RESIDENCE (Where deceased lived. If institution; residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>BALTO</u><br>C. CITY OR TOWN <u>Baltimore</u> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <u>25 Warren Park Dr. Apt B1</u> |   |   |  |
| 5. SEX <u>MALE</u>   | 6. RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><u>4-30-01</u>         | 9. AGE (In years lost birthday)<br><u>70</u>  | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>PHARMACIST</u> |   |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>MARYLAND</u>   |                      |   | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u> |   |   | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>RETAIL</u>                          |  |
| 13. FATHER'S NAME<br><u>SAMUEL WEINBERG</u>  |                      |   |  | 14. MOTHER'S MAIDEN NAME<br><u>MARY RIEMELSBERG</u>   |   |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>NO</u>  |                      | 16. SOCIAL SECURITY NO.<br><u>219-01-1966</u>   |  | 17. INFORMANT<br><u>EDWIN LIPOWITZ, <del>XXXXXX</del></u> ADDRESS<br><u>1004 FLAGTREE LANE</u>  |   |   |  |
| 18. <u>519.3 41 250.9</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><u>Respiratory failure, shock</u><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>C.O.P.D. Cor-pulmonal</u><br><u>Diabetes Mellitus</u> |                      |   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Aspiration - suspected.</u><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><u>Diabetes Mellitus</u><br>(C) _____  |   |   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                      |   |  |   |   |   |  |
| 19A. DATE OF OPERATION<br><u>0</u>   |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)   |   | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?        |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |   |   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)   |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |   |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <u>1-13</u> 19 <u>72</u> to <u>1-26</u> 19 <u>72</u> that (I) (we) last saw the deceased alive on <u>1-26-72</u> 19 <u>72</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |                      |   |  |   |   |   |  |
| 23A. SIGNATURE<br><u>Dr. Silver</u>  |                      |   |  | 23B. DATE SIGNED<br><u>1-26-72</u>  |   | 23C. PHYSICIAN'S NAME (Type)<br><u>DR. SILVER, Attending Physician</u>      |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>  |                      | 24B. DATE<br><u>1-27-72</u>   |  | 24C. NAME OF CEMETERY or CREMATORY<br><u>HEBREW FRIENDSHIP,</u>   |   | 24D. LOCATION (City, town, or county) (State)<br><u>BALTIMORE, MARYLAND</u> |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>JAN 31 1972</u>  |                      | 25B. NAME OF REGISTRAR<br><u>210 000</u>  |  | 25C. FUNERAL DIRECTOR<br><u>SOL LEVINSON &amp; BROS.</u>  |   | ADDRESS<br><u>6010 REISTERSTOWN ROAD</u>                                    |  |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                  |   |  | REG. NO. <b>72 00980</b>  |  |
|--|------------------|---|--|---|--|
| 7-123 72 00980   |                  |   |  | CERTIFICATE OF DEATH  |  |
| BIRTH NO.  |                  | 1. NAME OF DECEASED<br>(Type or Print)  |  | 2. DATE AND HOUR OF DEATH   |  |
|  |                  | RAE ZEBEST  |  | JANUARY 25, 1972 12:30 P. M.  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                  |   | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)                |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><br>3014 FALLSTAFF MANOR COURT, APT. C<br>00   |                  |   | A. STATE<br>MARYLAND   |   |  |
|  |                  |   | B. COUNTY<br>BALTIMORE   |   |  |
|  |                  |   | C. CITY OR TOWN<br>BALTIMORE   |   | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input type="checkbox"/> |
|  |                  |   | E. STREET AND NUMBER<br>3014 FALLSTAFF MANOR COURT, APT. C   |   |  |
| 5. SEX<br>FEMALE   | 6. RACE<br>WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br>SEPT. 18, 1905   | 9. AGE (In years last birthday)<br>66                                 | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                             |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |                  | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 11. BIRTHPLACE (State or foreign country)                             |  |
| BOOKKEEPER   |                  | MASONIC TEMPLE BLDG.  |  | RUSSIA  |  |
| 13. FATHER'S NAME<br>MAX ZEBEST  |                  |   | 14. MOTHER'S MAIDEN NAME<br>REBECCA LAPIDUS  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO   |                  | 16. SOCIAL SECURITY NO.<br>578-01-2970  |  | 17. INFORMANT<br>MISS MARY ZEBEST, 24 BRETON HILL RD., APT. 2A        |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><br>4/10/9 I<br>CAUSE OF DEATH<br><br>DISEASE OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><br>19A. DATE OF OPERATION<br>0 |                  |   | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 day<br>57 years                                    |   |  |
| 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                  |   | 20A. AUTOPSY? (Yes or No)  |   |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)  |                  |   | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)             |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                  |   | 21E. INJURY OCCURRED<br>While At <input type="checkbox"/> Not While At Work <input type="checkbox"/> |   |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |                  |   | 21F. HOW DID INJURY OCCUR?   |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from 2/14 1960 to 1/25 1972, that (I) (we) last saw the deceased alive on 1/25 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |                  |   |  |   |  |
| 23A. SIGNATURE<br>28 Zimberg MD. DEGREE  |                  |   |  | 23B. DATE SIGNED<br>1/25/72   |  |
| 23C. PHYSICIAN'S NAME (Type)<br>ISRAEL ZINBERG   |                  |   |  | 23D. ADDRESS<br>4000 W. NORTHERN PKWY.                                |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL   |                  | 24B. DATE<br>1-26-72  |  | 24C. NAME OF CEMETERY or CREMATORY<br>SHOMREI MISHMERES               |  |
| 24D. LOCATION (City, town, or county) (State)<br>XX ROSEDALE, MARYLAND   |                  |   |  |   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>JAN 31 1972   |                  | 25B. NAME OF REGISTRAR<br>26-48-3-62, 220 0 0 0 0 0 0   |  | 25C. FUNERAL DIRECTOR<br>SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD |  |

12-10-58

12-10-58

TO: DIRECTOR, FBI  
FROM: SAC, NEW YORK  
SUBJECT: [illegible]  
RE: [illegible]

1. [illegible]  
2. [illegible]  
3. [illegible]  
4. [illegible]  
5. [illegible]

Very truly yours,  
[Signature]  
Special Agent in Charge

Enclosure

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00981

BIRTH NO.

|  |  |   |  |
|--|--|---|--|
| 1. NAME OF DECEASED<br>(Type or Print) <b>BARRY Leonard B. Blechman</b>  |  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month <b>1</b> Day <b>26</b> Year <b>72</b> Hour <b>1:40 a.</b> |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>6624 Vincent La., APT. 202</b>  |  | 3. DATE PRONOUNCED DEAD<br>Month <b>1</b> Day <b>26</b> Year <b>72</b> Hour <b>1:40 a.</b>  |  |
| 6. SEX<br><b>male</b>  |  | 7. RACE<br><b>White</b>   |  |
| 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | C. CITY OR TOWN<br><b>BALTIMORE</b>   |  |
| 9. DATE OF BIRTH<br><b>MAY 9, 1943</b>   |  | 10. AGE (In years last birthday)<br><b>28</b>   |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>BALTIMORE, MARYLAND</b>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |  |
| 13. FATHER'S NAME<br><b>SIMON B. BLECHMAN</b>  |  | 14. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>PIANIST</b>  |  |
| 15. MOTHER'S MAIDEN NAME<br><b>ROSE SPECTOR</b>  |  | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>NO</b>  |  |
| 17. SOCIAL SECURITY NO.<br><b>212-42-8581</b>  |  | 18. INFORMANT<br><b>MR. SIMON B. BLECHMAN, 6624 VINCENT LANE, APT. 202</b>  |  |
| 19. <b>422X</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, osteoarthritis, etc. It means the disease, injury or complication which caused death.)<br><b>Acute Myocarditis</b>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |   |  |
| 20A. DATE OF OPERATION<br><b>2</b>   |  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 21. AUTOPSY? (Yes or No)<br><b>yes</b>   |  |   |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.   |  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 22C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |   |  |
| 22D. TIME (Month) (Day) (Year) (Hour) (Approx.)  |  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  |
| 22F. HOW DID INJURY OCCUR?   |  |   |  |
| 23.<br>I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br>ACTUAL SIGNATURE <b>Peter Lipkovic, M.D.</b><br>EXAMINER'S NAME (Type)<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED <b>1/26/72</b> |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>  |  | 24B. DATE<br><b>1-27-72</b>   |  |
| 24C. NAME of CEMETERY or CREMATORY<br><b>AGUDAS ACHIM ANSHE SFARD</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>ROSEDALE, MARYLAND</b>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 31 1972</b>  |  | 25B. NAME OF REGISTRAR<br><b>Sol Levinson</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>SOL LEVINSON &amp; BROS., 6010 REISTERSTOWN ROAD</b>   |  | ADDRESS   |  |

2-18-1972 - Completion of cause of death on a pending medical examiner death certificate  
Peter Lipkovic, M.D.

HRS



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

VS 150-REV. 1/1/68

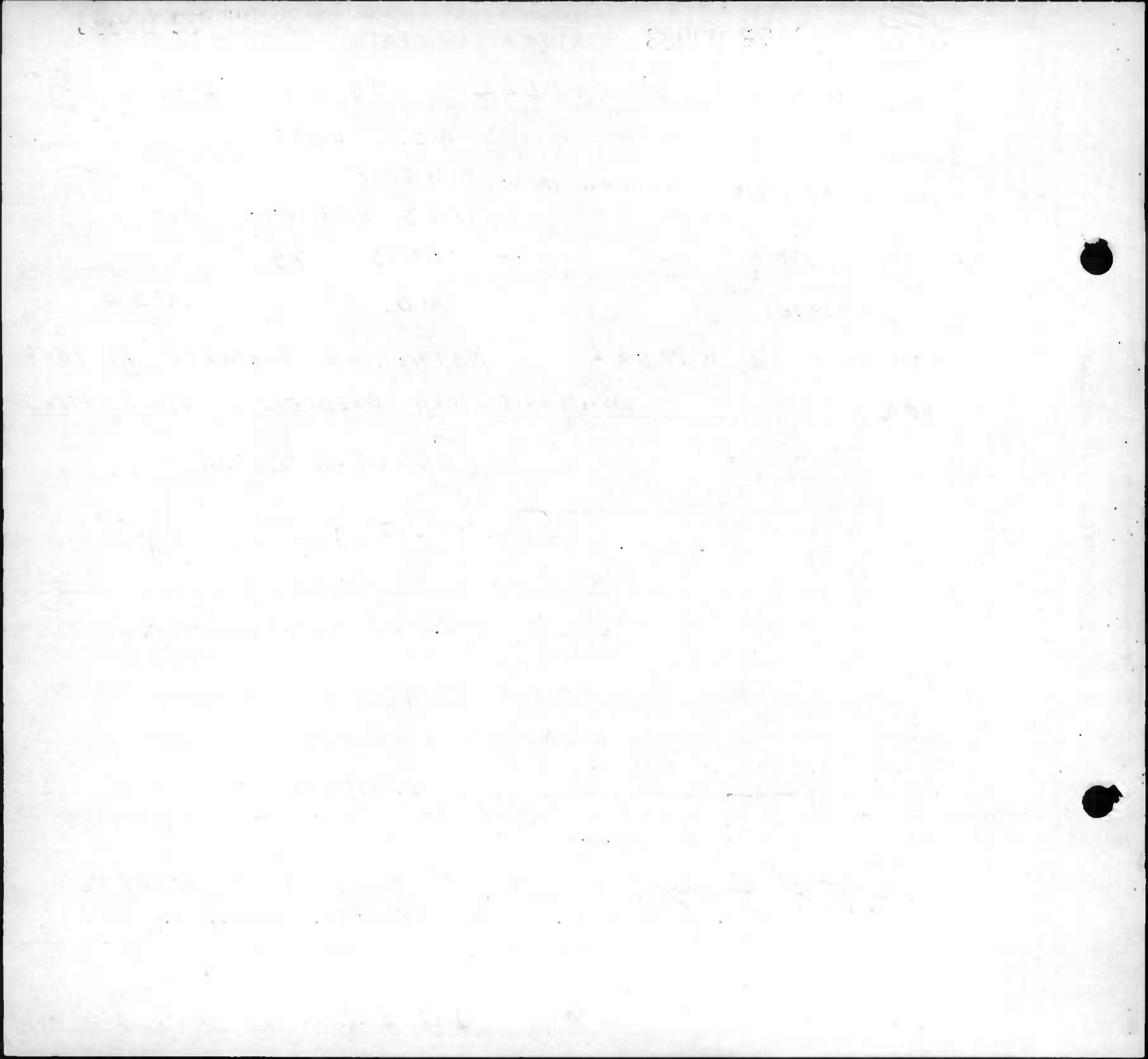
11/4/72 - Adm.

1602 Howard Ave. 21221

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| K-514   |  | 72-00983   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. 72 00983  |  |
| BIRTH NO.   |  |  |  | 2. DATE AND HOUR OF DEATH   |  |  |  |
| 1. NAME OF DECEASED<br>(Type or Print) WILLIAM F. KNOBEL  |  |  |  | JAN. 27, 1972 3:55A.M.  |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |  |  | 4. USUAL RESIDENCE (Where deceased lived; If institution; residence before admission) |  |  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)   |  |  |  | A. STATE B. COUNTY  |  |  |  |
| HOUSE OF PINES NURSING HOME   |  |  |  | MD. BALTO   |  |  |  |
| BELAIR RD   |  |  |  | C. CITY OR TOWN D. INSIDE CITY LIMITS?  |  |  |  |
| ROSEDALE  |  |  |  | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>                   |  |  |  |
| E. STREET AND NUMBER  |  |  |  | 1523 ROSEWICK AVE   |  |  |  |
| 5. SEX  |  | 6. RACE  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>            |  | 8. DATE OF BIRTH   |  |
| M   |  | W  |  | WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>         |  | 1/16/93  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)   |  | 12. CITIZEN OF WHAT COUNTRY?   |  |
| LABORER   |  |  |  | MD.   |  | USA  |  |
| 13. FATHER'S NAME   |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |  |
| LAWRENCE J. KNOBEL  |  |  |  | KATHERINE LOESCHEL KNOBEL   |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  |  |  | 16. SOCIAL SECURITY NO.   |  | 17. INFORMANT ADDRESS  |  |
| N/A   |  |  |  | 218-07-6418   |  | VIOLA GREDLEIN 714 S. 49TH ST  |  |
| 18. 412.3 I DISEASE OR CONDITION DIRECTLY LEADING TO DEATH  |  |  |  | CAUSE OF DEATH  |  |  |  |
| (This does not mean the mode of dying, e.g., heart failure, asthenia, etc. It means the disease, injury or complication which caused death.)  |  |  |  | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:                                   |  |  |  |
| ANTECEDENT CAUSES   |  |  |  | Antisocial Heart Drain  |  |  |  |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |  |  |  | (B) Generalized Antisocial  |  |  |  |
|   |  |  |  | (C) Due to, or as a consequence of:   |  |  |  |
| II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |  | Similar Dementia; Ch. Ulcering Tissue Infection; Little Kidney                        |  |  |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 0   |  |  |  |   |  |  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |  |  |
| 21D. TIME OF INJURY (APPROX.)   |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
|   |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>        |  |   |  |  |  |
| 22. I certify that (I) (the hospital) attended the deceased from 6/27/1970 to 1/27/1972 that (I) (we) last saw the deceased alive on 1/19/1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. |  |  |  |   |  |  |  |
| 23A. SIGNATURE  |  |  |  | 23B. DATE SIGNED  |  |  |  |
| Albert B. Bradley   |  |  |  | 1/28/72   |  |  |  |
| 23C. PHYSICIAN'S NAME (Type) ALBERT B. BRADLEY, M.D.  |  |  |  | 23D. ADDRESS  |  |  |  |
|   |  |  |  | 4900 Belair Rd. Balto., Md. 21206   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)  |  | 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATORY  |  | 24D. LOCATION (City, town, or county) (State)                        |  |
| BURIAL  |  | 1/29/72  |  | ZION LUTHERAN   |  | BALTO. MD.   |  |
| 25A. DATE REC'D BY HEALTH DEPT.   |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR   |  | ADDRESS  |  |
| JAN 31 1972   |  | O. G. CONNELLY   |  | O. G. CONNELLY SONS   |  | 300 MACT   |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

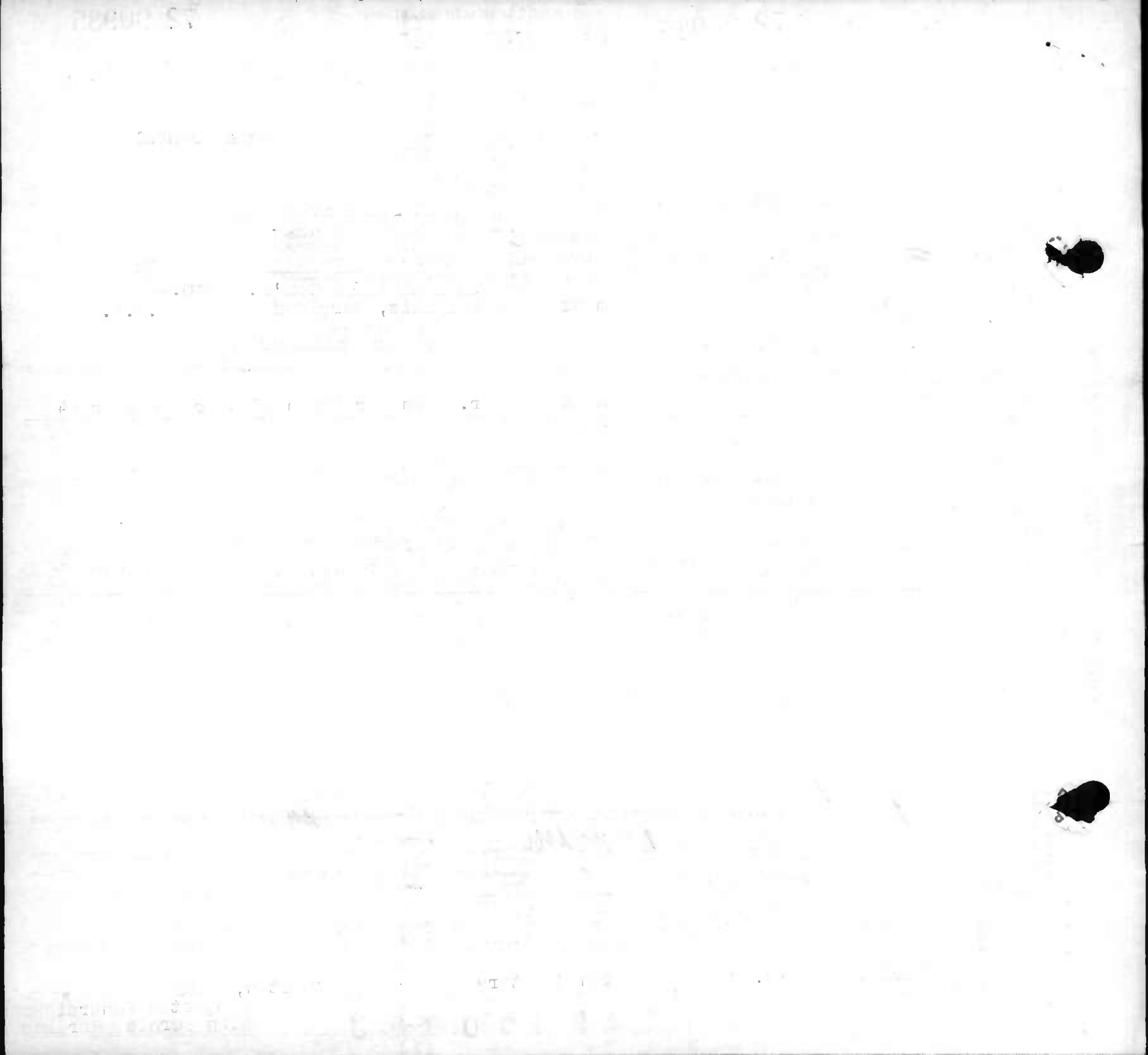
|   |  |   |  |   |  |   |  |
|---|--|---|--|---|--|---|--|
| BIRTH NO. <u>520</u>  |  | 72 00984  |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <u>72 00984</u>  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>James, Glen DORRIS</u>  |  |   |  | 2. DATE AND HOUR OF DEATH<br><u>1-26-72</u>   <u>3</u> <u>30</u> P.M.   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |  |   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE <u>Maryland</u> B. COUNTY <u>Baltimore</u> |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>31 Baltimore City Hospitals</u><br><u>4940 Eastern Avenue</u><br><u>Baltimore, Md. 21224</u>   |  |   |  | C. CITY OR TOWN<br><u>ESSEX</u>   |  | D. INSIDE CITY LIMITS?<br>YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |  |
| 5. SEX <u>Male</u> 6. RACE <u>Caucasian</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |  |   |  | 8. DATE OF BIRTH<br><u>8-11-1924</u>  |  | 9. AGE (in years last birthday) <u>47</u>   |  |
| 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>BRICK LAYER</u>  |  |   |  | 11. BIRTHPLACE (State or foreign country)<br><u>W. VA.</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>USA</u>  |  |
| 13. FATHER'S NAME<br><u>DORRIS JAMES</u>  |  |   |  | 14. MOTHER'S MAIDEN NAME<br><u>JANIE FLESHER</u>  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>YES</u> <u>WW II</u>   |  |   |  | 16. SOCIAL SECURITY NO.<br><u>235-20-2325</u>   |  | 17. INFORMANT<br><u>Records: BCH 4940 Eastern Avenue 21224</u>                                |  |
| 18. <u>41018 I</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |  |   |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><u>Multiple pulmonary emboli</u>  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>2 days</u>                                 |  |
|   |  |   |  | (B) <u>Acute myocardial infarction</u>  |  | <u>4 days</u>   |  |
|   |  |   |  | (C) <u>Arteriosclerotic cardiovascular disease</u>  |  | <u>See gross</u>  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><u>X 2 x x x x x</u>  |  |   |  |   |  | <u>x x x x</u>  |  |
| 19A. DATE OF OPERATION<br><u>0</u>  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 20A. AUTOPSY? (Yes or No)<br><u>No</u>  |  | 20B. (IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?)                        |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner)<br><input type="checkbox"/>   |  | 21B. PLACE OF (INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)<br><input type="checkbox"/> |  | 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |  |   |  |
| 21D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>             |  | 21F. HOW DID INJURY OCCUR?  |  |   |  |
| 22. I certify that (I) ( <del>this hospital</del> ) attended the deceased from <u>Jan. 22 1972</u> to <u>Jan. 26 1972</u> that (I) ( <del>we</del> ) last saw the deceased alive on <u>Jan. 26 1972</u> and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above. (I) ( <del>we</del> ) ( <del>did not</del> ) view the body after death. |  |   |  |   |  |   |  |
| 23A. SIGNATURE<br><u>J. E. Menitove, MD</u>   |  |   |  | 23B. DATE SIGNED<br><u>1-26-72</u>  |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>JAY E. MENITOVE, MD</u>  |  |   |  | 23D. ADDRESS<br><u>Balt. City Hosp., Balt. Md. 21224</u><br><u>4940 Eastern Avenue, Baltimore, Md. 21224</u>                                |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>BURIAL</u>   |  | 24B. DATE<br><u>1/29/72</u>   |  | 24C. NAME OF CEMETERY OR CREMATORY<br><u>HOLLY HILL CEM</u>   |  | 24D. LOCATION<br>(City, town, or county) <u>BALTO. MD.</u> (State) <u>MD.</u>                 |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>JAN 31 1972</u>   |  | 25B. NAME OF REGISTRAR<br><u>REG. SEC. [Signature]</u>  |  | 25C. FUNERAL DIRECTOR<br><u>J. E. CONNELLY</u>  |  | ADDRESS<br><u>300 MACE</u>  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |   |  |
|--|--|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT   |  | 72 00985  |  |
| P-625- 72 00985  |  | REG. NO. 72 00985   |  |
| BIRTH NO. <u>Annapolis, Md.</u>  |  | CERTIFICATE OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <u>BRIAN PARKINSON</u>  |  | 2. DATE AND HOUR OF DEATH<br><u>1045 PM JAN 26 1972</u>   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)                                   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><u>33 The Johns Hopkins Hospital</u>   |  | A. STATE <u>Maryland</u><br>B. COUNTY <u>Anne Arundel</u>   |  |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | C. CITY OR TOWN <u>Gambrills</u><br>D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>     |  |
| 5. SEX <u>Male</u>   |  | 6. RACE <u>Cauc.</u>  |  |
| 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>  |  | 8. DATE OF BIRTH <u>7/4/71</u>  |  |
| WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | 9. AGE (In years last birthday) <u>6</u>  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><u>none</u>   |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><u>none</u>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><u>Annapolis, Maryland</u>  |  | 12. CITIZEN OF WHAT COUNTRY?<br><u>U.S.A.</u>   |  |
| 13. FATHER'S NAME<br><u>J. Timothy Parkinson</u>   |  | 14. MOTHER'S MAIDEN NAME<br><u>Marcia Phillips</u>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><u>no</u>  |  | 16. SOCIAL SECURITY NO.<br><u>none</u>  |  |
| 17. INFORMANT<br><u>Mr. John Parkinson (father)</u>  |  | ADDRESS<br><u>Same As #4</u>  |  |
| 18. <u>758.81</u><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><u>II</u><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><u>Hydrocephalus</u> |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><u>12 days</u><br><u>6 months</u><br><u>6 months</u><br><u>3 months</u> |  |
| 19A. DATE OF OPERATION<br><u>2</u>   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY (Yes or No)<br><u>Yes</u>   |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><u>no</u>                                       |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)<br><input type="checkbox"/>  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)                                |  |
| 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  | 21D. TIME OF INJURY (Month) (Day) (Year) (Hour)<br>(APPROX.)  |  |
| 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (1) (this hospital) attended the deceased from <u>January 14 1972</u> to <u>Jan 26 1972</u><br>that (1) (we) last saw the deceased alive on <u>Jan 26 1972</u> and that in (our) opinion death occurred on the date and hour and from the causes stated above. (1) (We) (did) (not) view the body after death.  |  |   |  |
| 23A. SIGNATURE<br><u>Alan Cooper Smith MD</u>  |  | 23B. DATE SIGNED<br><u>Jan 26 1972</u>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><u>Alan COOPERSMITH MD</u>   |  | 23D. ADDRESS<br><u>The Johns Hopkins Hospital</u>   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><u>Burial</u>  |  | 24B. DATE<br><u>Jan. 28/72</u>  |  |
| 24C. NAME OF CEMETERY or CREMATORY<br><u>Somerton Cemetery</u>   |  | 24D. LOCATION (City, town, or county) (State)<br><u>Somerton, Ohio</u>  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><u>JAN 31 1972</u>  |  | 25B. NAME OF REGISTRAR<br><u>Blair J. ...</u>   |  |
| 25C. FUNERAL DIRECTOR<br><u>Singleton Funeral Home</u>   |  | ADDRESS<br><u>Glen Burnie, Maryland</u>   |  |





## FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |   |  |
|--|--|--|--|---|--|
| 4-155-72 00986<br>BIRTH NO. 72 00986   |  | BALTIMORE CITY DEPARTMENT<br>CERTIFICATE OF DEATH  |  | REG. NO. 72 00986   |  |
| 1. NAME OF DECEASED<br>(Type or Print) John Hoffman Hospital   |  | 2. DATE AND HOUR OF DEATH<br>1-26-72 3:30 A.M.   |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>The Johns Hopkins Hospital 2-18-72  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE Maryland<br>B. COUNTY 2403   |  |   |  |
| 5. SEX m   |  | 6. RACE Caucasian  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  |
| 8. DATE OF BIRTH 1-18-72   |  | 9. AGE (In years last birthday) 0 38   |  | 10. If Under 1 Yr. Months: Days: Hours: Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none   |  | 10B. KIND OF BUSINESS OR INDUSTRY none   |  | 11. BIRTHPLACE (State or foreign country) Baltimore, Maryland   |  |
| 12. CITIZEN OF WHAT COUNTRY U.S.A.   |  | 13. FATHER'S NAME Clifford Hoffman   |  | 14. MOTHER'S MAIDEN NAME Renelde Lee Mabe   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) no  |  | 16. SOCIAL SECURITY NO. none   |  | 17. INFORMANT Mr. Clifford N. Hoffman (father) Same As #4   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>DISEASE OR CONDITION<br>ANTECEDENT CAUSES<br>DISEASE OR CONDITIONS<br>UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>Cardiac collapse<br>acidosis postoperatively<br>Congenital heart disease<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) Frank's arteriosclerosis congenital |  |   |  |
| 19A. DATE OF OPERATION 1-25-72   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED Congenital heart defect   |  | 20A. AUTOPSY? (Yes or No) YES   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) NO   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  | 21F. HOW DID INJURY OCCUR?  |  |
| 22. I certify that (this hospital) attended the deceased from 1-25 1972 to 1-26 1972 that (I) last saw the deceased alive on 1-26 1972 and that (in my) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did not) view the body after death.                  |  |  |  |   |  |
| 23A. SIGNATURE Hugh Robinson MD  |  |  |  | 23B. DATE SIGNED 1-26-72  |  |
| 23C. PHYSICIAN'S NAME (Type) Hugh Robinson, MD.  |  |  |  | 23D. ADDRESS The Johns Hopkins Hospital   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify) Burial  |  | 24B. DATE Jan. 29/72   |  | 24C. NAME of CEMETERY or CREMATORY Glen Haven Memorial Park   |  |
| 24D. LOCATION (City, town, or county) Glen Burnie, Maryland  |  | 24E. NAME of REGISTRAR   |  | 24F. FUNERAL DIRECTOR Singleton Funeral Home  |  |
| 25A. DATE REC'D BY HEALTH DEPT. JAN 31 1972  |  | 25B. NAME OF REGISTRAR   |  | 25C. FUNERAL DIRECTOR   |  |

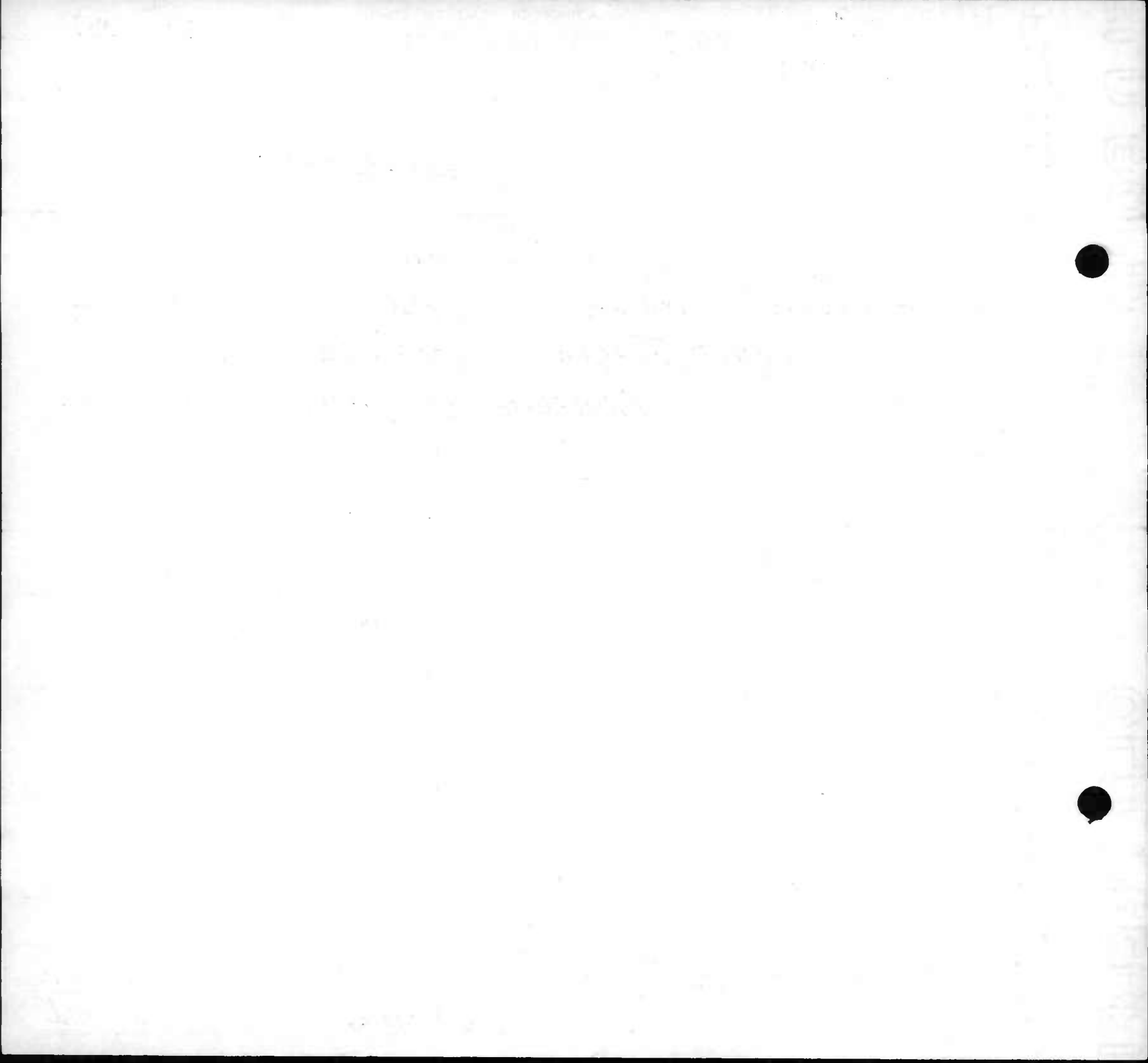
2-18-72 - Information from Birth Certificate Baltimore City Hospital and  
Funeral Director. HS

IIII

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

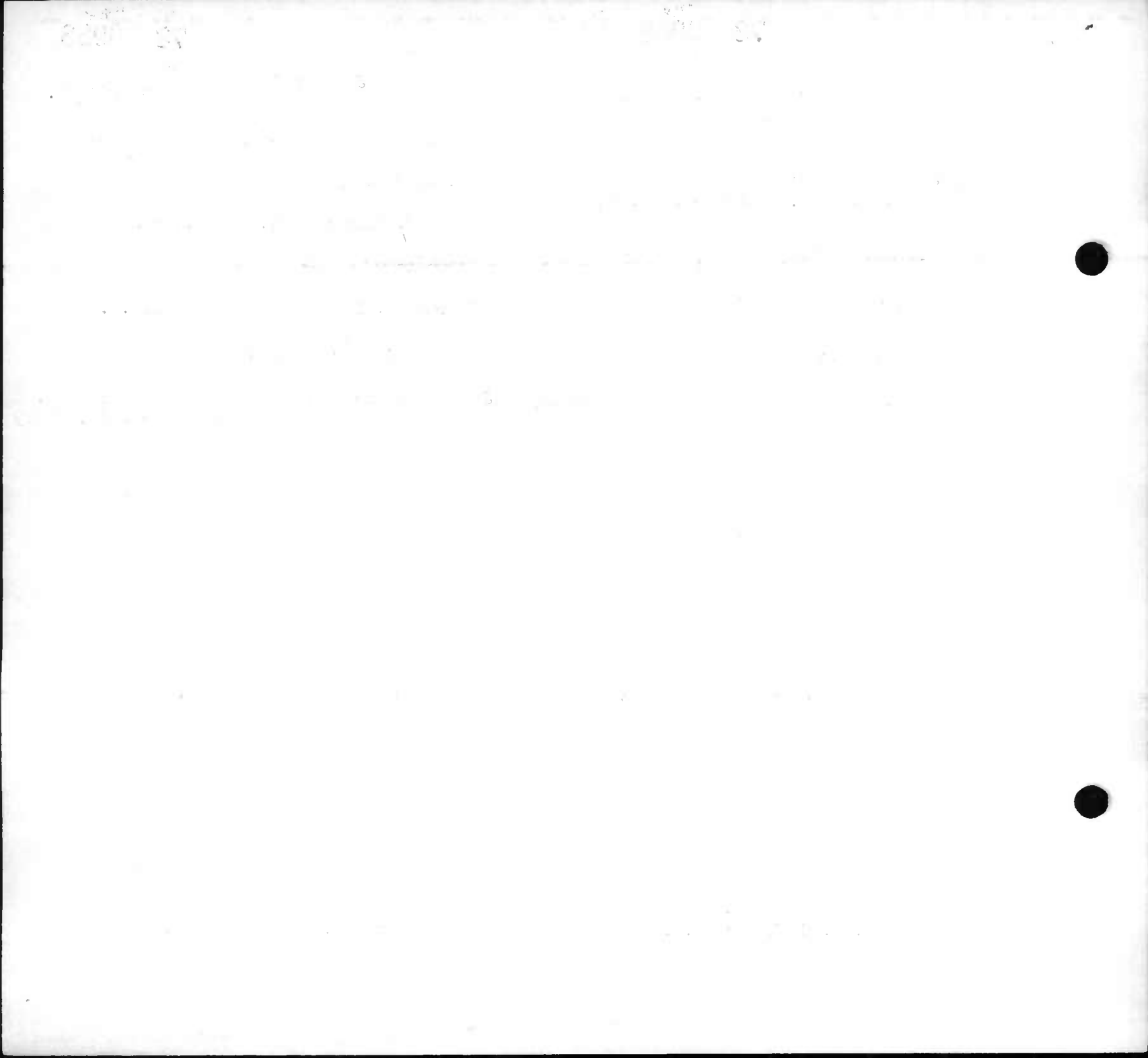
|   |  |   |
|---|--|---|
| <div style="display: flex; justify-content: space-between;"> <span>G-650</span> <span>72 00987</span> <span>CITY HEALTH DEPARTMENT</span> </div> <h2 style="text-align: center;">CERTIFICATE OF DEATH</h2>  |  | REG. NO. <span style="font-size: 1.2em;">72 00987</span>  |
| 1. NAME OF DECEASED<br>(Type or Print) <span style="font-size: 1.2em;">GRIMM, SADIE L.</span>   |  | 2. DATE AND HOUR OF DEATH<br><span style="font-size: 1.2em;">JAN. 26, 1972</span> <span style="font-size: 1.2em;">11:40 A.M.</span>   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><span style="font-size: 1.5em;">42</span> <span style="font-size: 1.2em;">SINAI HOSPITAL BALTIMORE</span>  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <span style="font-size: 1.2em;">MD</span> B. COUNTY <span style="font-size: 1.2em;">BALTIMORE</span><br>C. CITY OR TOWN <span style="font-size: 1.2em;">BALTIMORE</span> D. INSIDE CITY LIMITS? <span style="font-size: 1.2em;">5300</span><br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/><br>E. STREET AND NUMBER <span style="font-size: 1.2em;">3616 PRIARSTONE RD., RANDALLSTOWN</span> |
| 5. SEX <span style="font-size: 1.2em;">F</span>   | 6. RACE <span style="font-size: 1.2em;">W</span>   | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>  |
| 8. DATE OF BIRTH <span style="font-size: 1.2em;">1/11/93</span>   |  | 9. AGE (In years last birthday) <span style="font-size: 1.2em;">75</span><br>If Under 1 Yr. Months: Days: If Under 24 Hrs. Hours: Min.  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <span style="font-size: 1.2em;">HOUSEWIFE</span>  |  | 10B. KIND OF BUSINESS OR INDUSTRY <span style="font-size: 1.2em;">Home</span>   |
| 11. BIRTHPLACE (State or foreign country) <span style="font-size: 1.2em;">MD</span>   |  | 12. CITIZEN OF WHAT COUNTRY? <span style="font-size: 1.2em;">U.S.A</span>   |
| 13. FATHER'S NAME <span style="font-size: 1.2em;">August Teager</span>  |  | 14. MOTHER'S MAIDEN NAME <span style="font-size: 1.2em;">CAROLINE P</span>  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <span style="font-size: 1.2em;">NO</span>  |  | 16. SOCIAL SECURITY NO. <span style="font-size: 1.2em;">678-01-36448</span>   |
| 17. INFORMANT <span style="font-size: 1.2em;">Jesse P. Grimm.</span> ADDRESS <span style="font-size: 1.2em;">same as #4</span>  |  |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><span style="font-size: 1.5em;">410.9 + 250.9</span><br><b>ACUTE MYOCARDIAL INFARCTION</b><br>(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:<br><span style="font-size: 1.2em;">ARTERIO-SCLEROTIC CARDIOVASC. DISEASE</span><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____<br>APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <span style="font-size: 1.2em;">4 days</span> |  |   |
| 19. ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><span style="font-size: 1.2em;">PNEUMONIA, DIABETES MELLITUS</span>   |  |   |
| 19A. DATE OF OPERATION <span style="font-size: 1.2em;">0</span>   | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   | 20A. AUTOPSY? (Yes or No) <span style="font-size: 1.2em;">NO</span>   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> | 21F. HOW DID INJURY OCCUR?  |
| 22. I certify that (1) (this hospital) attended the deceased from <span style="font-size: 1.2em;">DEC. 19</span> 19 <span style="font-size: 1.2em;">71</span> to <span style="font-size: 1.2em;">JAN. 26</span> 19 <span style="font-size: 1.2em;">72</span> that (2) (we) last saw the deceased alive on <span style="font-size: 1.2em;">JAN. 26</span> 19 <span style="font-size: 1.2em;">72</span> and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death.                           |  |   |
| 23A. SIGNATURE <span style="font-size: 1.2em;">Armando C. D'Amico, M.D.</span>  |  | 23B. DATE SIGNED <span style="font-size: 1.2em;">Jan. 26, 1972</span>   |
| 23C. PHYSICIAN'S NAME (Type) <span style="font-size: 1.2em;">ARMANDO C. D'AMICO, M.D.</span>  |  | 23D. ADDRESS <span style="font-size: 1.2em;">Sinai Hosp. Baltimore</span>   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <span style="font-size: 1.2em;">BURIAL</span>  | 24B. DATE <span style="font-size: 1.2em;">1-29-1972</span>   | 24C. NAME OF CEMETERY OR CREMATORY <span style="font-size: 1.2em;">Springfield</span>   |
| 24D. LOCATION (City, town, or county) (State) <span style="font-size: 1.2em;">Sykesville CARROLL, MD</span>   |  |   |
| 25A. DATE REC'D BY HEALTH DEPT. <span style="font-size: 1.2em;">JAN 31 1972</span>  | 25B. NAME OF REGISTRAR <span style="font-size: 1.2em;">R. H. 282, NO. 0 0 0</span>                     | 25C. FUNERAL DIRECTOR ADDRESS <span style="font-size: 1.2em;">G.M. WOLF, Box 326, Sykesville, MD</span>   |



FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |
|---|--|--|--|
| <p><b>72 00988</b></p> <p>BALTIMORE CITY HEALTH DEPARTMENT</p> <p><b>CERTIFICATE OF DEATH</b></p>   |  | <p>REG. NO. <b>72 00988</b></p>  |  |
| <p>BIRTH NO. <b>M-460</b></p>   |  | <p>1. NAME OF DECEASED<br/>(Type or Print) <b>Katharine Elizabeth Mulry</b></p>  |  |
| <p>2. DATE AND HOUR OF DEATH<br/><b>January 26, 1972</b> <b>9:05 A.M.</b></p>   |  | <p>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</p>  |  |
| <p>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br/><b>Jenkins Memorial Hospital<br/>1000 Caton Ave. Baltimore, Md. 21229</b></p>  |  | <p>4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br/>A. STATE <b>Md.</b> B. COUNTY <b>Baltimore City</b></p> |  |
| <p>5. SEX <b>Female</b> 6. RACE <b>White</b> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/></p>   |  | <p>8. DATES OF BIRTH <b>2/27/1917</b> 9. AGE (in years last birthday) <b>54</b> 10. UNDER 1 Yr. Months Days 11. UNDER 24 Hrs. Min.</p>               |  |
| <p>10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br/><b>Retired practical nurse</b></p>   |  | <p>11. BIRTHPLACE (State or foreign country)<br/><b>Roscommon, Ireland</b></p>   |  |
| <p>12. CITIZEN OF WHAT COUNTRY?<br/><b>U.S.A.</b></p>   |  | <p>13. FATHER'S NAME<br/><b>Edward Mulry</b></p>   |  |
| <p>14. MOTHER'S MAIDEN NAME<br/><b>Catherine Colin Conway</b></p>   |  | <p>15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br/><b>No.</b></p>                       |  |
| <p>16. SOCIAL SECURITY NO.<br/><b>219-26-4977</b></p>   |  | <p>17. INFORMANT ADDRESS<br/><b>Jenkins Memorial Hospital 1000 Caton Ave. Baltimore, Md. 21229</b></p>   |  |
| <p>18. CAUSE OF DEATH</p> <p><b>I</b></p> <p>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</p> <p>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>Myocardial infarction</b></p> <p><b>II</b></p> <p>ANTECEDENT CAUSES</p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><b>Coronary art. dis.</b></p> |  |  |  |
| <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).</p>   |  |  |  |
| <p>19A. DATE OF OPERATION</p>   |  | <p>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</p>  |  |
| <p>20A. AUTOPSY? (Yes or No)</p>  |  | <p>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</p>  |  |
| <p>21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)</p>  |  | <p>21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>  |  |
| <p>21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)</p>   |  | <p>21D. TIME OF INJURY (Month) (Day) (Year) (Hour)</p>   |  |
| <p>21E. INJURY OCCURRED</p>   |  | <p>21F. HOW DID INJURY OCCUR?</p>  |  |
| <p>22. I certify that (I) (this hospital) attended the deceased from <b>March 1970</b> to <b>26 Jan 1972</b> that (I) (we) last saw the deceased alive on <b>26 Jan 1972</b> and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</p>   |  |  |  |
| <p>23A. SIGNATURE<br/><b>Lawrence Gallagher, M.D.</b></p>   |  | <p>23B. DATE SIGNED<br/><b>26 Jan 72</b></p>   |  |
| <p>23C. PHYSICIAN'S NAME (Type)<br/><b>L. R. Gallagher, M.D.</b></p>  |  | <p>23D. ADDRESS<br/><b>3455 Wilkens Ave. Baltimore, Md. 21229</b></p>  |  |
| <p>24A. BURIAL CREMATION, REMOVAL (Specify)<br/><b>Burial</b></p>   |  | <p>24B. DATE<br/><b>1/28/72</b></p>  |  |
| <p>24C. NAME OF CEMETERY or CREMATORY<br/><b>New Cathedral Cemetery</b></p>   |  | <p>24D. LOCATION (City, town, or county) (State)<br/><b>Baltimore, Maryland</b></p>  |  |
| <p>25A. DATE REC'D BY HEALTH DEPT.<br/><b>JAN 31 1972</b></p>   |  | <p>25B. NAME OF REGISTRAR<br/><b>John A. Moran, Jr.</b></p>  |  |
| <p>25C. FUNERAL DIRECTOR<br/><b>3000 E. Baltimore St. Baltimore, Md. 21224</b></p>  |  | <p>25D. ADDRESS</p>  |  |



G-642

72 00989 BALTIMORE CITY HEALTH DEPARTMENT

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

72 00989

BIRTH NO.

|   |                  |   |  |  |  |
|---|------------------|---|--|--|--|
| 1. NAME OF DECEASED<br>(Type or Print)<br>Walter L. Gerlock   |                  | 2. DATE OF DEATH<br>Known <input checked="" type="checkbox"/> Estimated <input type="checkbox"/><br>Month Day Year<br>1 25 72   |  | Hour<br>M.   |  |
| 4. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>31 Balto. City Hospital   |                  | 3. DATE PRONOUNCED DEAD<br>Month Day Year<br>1 25 72  |  | Hour<br>6:25 a. M.   |  |
| 5. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE Maryland B. COUNTY 53028  |                  |   |  |  |  |
| 6. SEX<br>male  | 7. RACE<br>White | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>   |  | C. CITY OR TOWN<br>Baltimore   |  |
| D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                  |   |  |  |  |
| 9. DATE OF BIRTH<br>9-23-1923   |                  | 10. AGE (In years last birthday)<br>48  |  | 11. Under 1 Yr. If Under 24 Hrs. Months Days Hours Min.                  |  |
| 12. BIRTHPLACE (State or foreign country)<br>Baltimore, Md  |                  | 13. CITIZEN OF WHAT COUNTRY?  |  | E. STREET AND NUMBER<br>33 E. Fort Howard                                |  |
| 14A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>Mechanicht helper  |                  | 14B. KIND OF BUSINESS OR INDUSTRY<br>Bethlem Steel Co   |  | 15. MOTHER'S MAIDEN NAME<br>Lottie Famous                                |  |
| 16. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)<br>no   |                  | 17. SOCIAL SECURITY NO.<br>213 20 0557  |  | 18. INFORMANT ADDRESS<br>Mrs. Walter Gerlock 33 E. Fort Ave Ft Howard    |  |
| 19. 412.4<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE (A) STATING THE UNDERLYING CONDITION LAST.   |                  | CAUSE OF DEATH<br>Arteriosclerotic cardiovascular disease<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br><br>(C) DUE TO, OR AS A CONSEQUENCE OF: |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                  |   |  |  |  |
| 20A. DATE OF OPERATION<br>2   |                  | 20B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  | 21. AUTOPSY? (Yes or No)<br>yes  |  |
| 22A. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.  |                  | 22B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  | 22C. WHERE DID (If in Baltimore City, give exact location) INJURY OCCUR? |  |
| 22D. TIME OF INJURY (APPROX.)<br>(Month) (Day) (Year) (Hour)<br>m.  |                  | 22E. INJURY OCCURRED<br>WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>   |  | 22F. HOW DID INJURY OCCUR?   |  |
| 23.<br>I certify that I held on Inquiry <input type="checkbox"/> Inspection <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> and that on this basis, death in my opinion resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/><br><br>ACTUAL SIGNATURE EXAMINER'S NAME (Type) Peter Lipkovic, M.D.<br>CHIEF MEDICAL EXAMINER <input type="checkbox"/><br>ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/><br>ASSOCIATE MEDICAL EXAMINER <input type="checkbox"/><br>DATE SIGNED 1/26/72 |                  |   |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>Burial  |                  | 24B. DATE<br>1-29-72  |  | 24C. NAME of CEMETERY or CREMATORY<br>Oak Lawn Cemetery                  |  |
| 24D. LOCATION (City, town, or county) (State)<br>Baltimore, Maryland  |                  |   |  |  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>JAN 31 1972  |                  | 25B. NAME OF REGISTRAR<br>Robert E. Bailey, M.D.  |  | 25C. FUNERAL DIRECTOR ADDRESS<br>WALTER DABROWSKI 1005 DUNDALK AVENUE    |  |

2-24-1972 - Completion of cause of death on a pending medical examiner death certificate  
Peter Lipkovic, M.D.

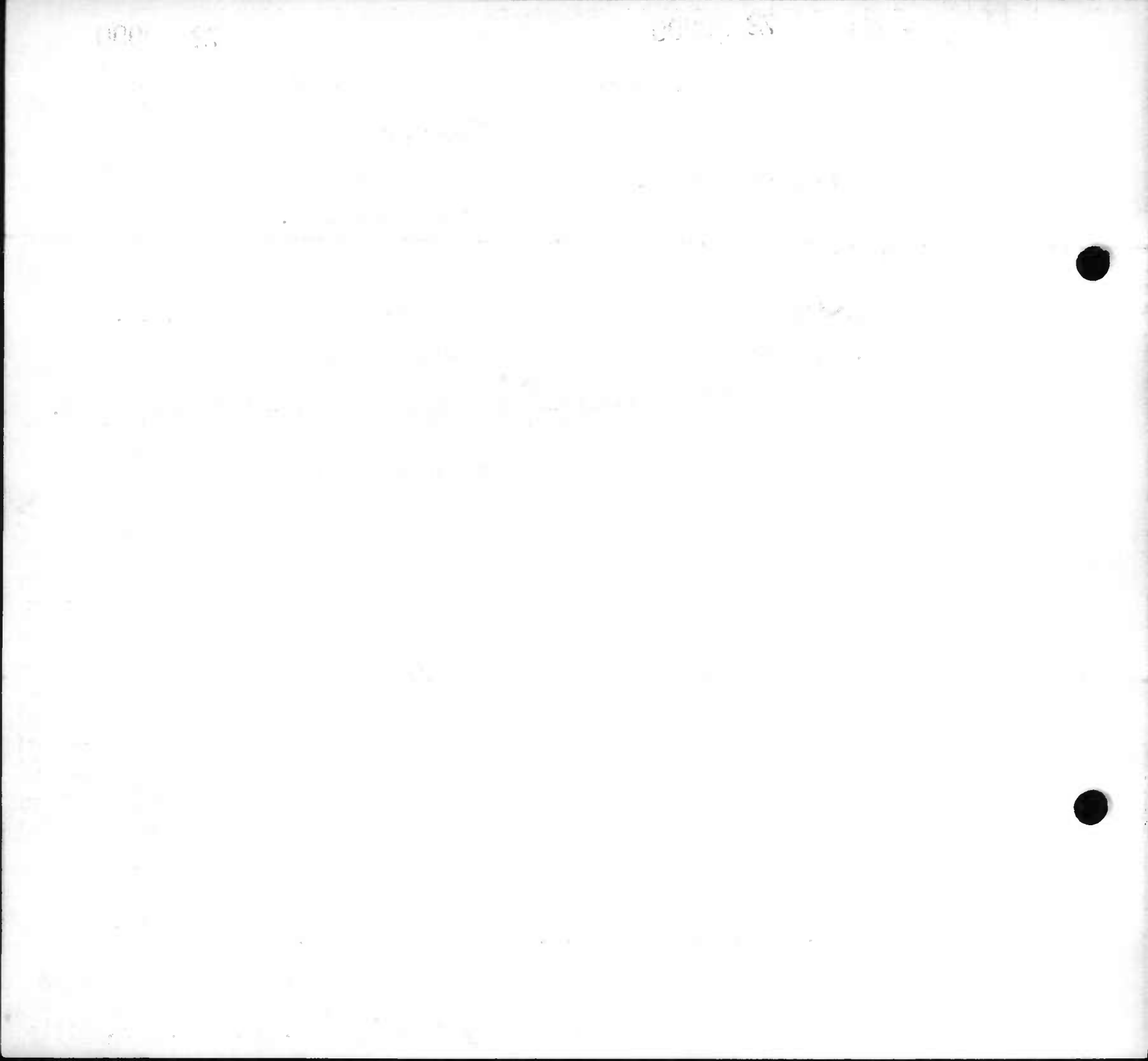
HRS



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

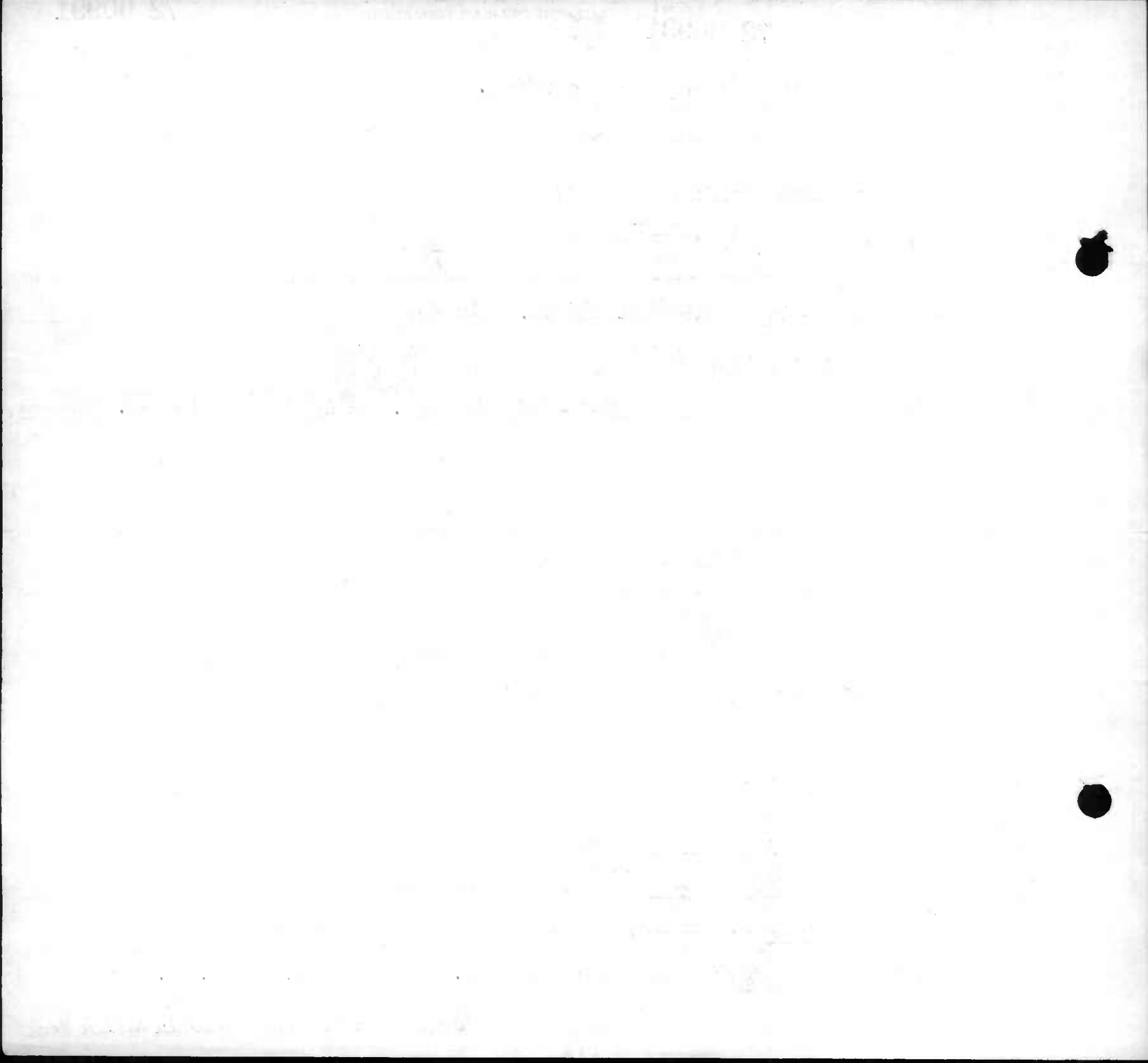
| BALTIMORE CITY HEALTH DEPARTMENT  |                         |   |                                     | REG. NO. <b>72 00990</b>   |  |
|---|-------------------------|---|-------------------------------------|--|--|
| D-120 72 00990  |                         |   |                                     | CERTIFICATE OF DEATH   |  |
| BIRTH NO.   |                         |   |                                     | 1. NAME OF DECEASED<br>(Type or Print) <b>Edith P. Davis</b>   |  |
| 2. DATE AND HOUR OF DEATH<br><b>1/26/72 10 A</b>  |                         |   |                                     | 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>00</b>   |                         | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>6205 Harford Rd.</b>   |                                     | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2745</b> |  |
| C. CITY OR TOWN<br><b>Baltimore</b>   |                         | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |                                     |  |  |
| E. STREET AND NUMBER<br><b>6205 Harford Rd.</b>   |                         |   |                                     |  |  |
| 5. SEX<br><b>Female</b>   | 6. RACE<br><b>White</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/13/83</b> | 9. AGE (In years last birthday)<br><b>88</b>   | If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Housewife</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY   |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>Virginia</b>   |  |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>   |                         | 13. FATHER'S NAME<br><b>John T. Roberts</b>   |                                     | 14. MOTHER'S MAIDEN NAME<br><b>Lillian Della</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>219-10-6492</b>   |                                     | 17. INFORMANT ADDRESS<br><b>Ethel Suchting - 6205 Harford Rd.</b>  |  |
| 18. CAUSE OF DEATH  |                         |   |                                     |  |  |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br><b>412.31</b><br><b>Anterolentic heart disease</b>  |                         |   |                                     |  |  |
| (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:   |                         |   |                                     |  |  |
| (B) DUE TO, OR AS A CONSEQUENCE OF:   |                         |   |                                     |  |  |
| (C) DUE TO, OR AS A CONSEQUENCE OF:   |                         |   |                                     |  |  |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).  |                         |   |                                     |  |  |
| 19A. DATE OF OPERATION<br><b>0</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     | 20A. AUTOPSY? (Yes or No)<br><b>No</b>   |  |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                         | 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner) <input type="checkbox"/>  |                                     |  |  |
| 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                         | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |                                     |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                     | 21F. HOW DID INJURY OCCUR?   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>19 57</b> to <b>Jan 26 19 72</b> that (I) (we) last saw the deceased alive on <b>Jan 25 19 72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. |                         |   |                                     |  |  |
| 23A. SIGNATURE<br><b>R. Donald Jandorf</b>  |                         |   |                                     | 23B. DATE SIGNED<br><b>1/27/72</b>   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>R. Donald Jandorf, M.D.</b>  |                         |   |                                     | 23D. ADDRESS<br><b>7403 Harford Rd.</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |                         | 24B. DATE<br><b>1/29/72</b>   |                                     | 24C. NAME OF CEMETERY or CREMATORY<br><b>Parkwood Cemetery</b>   |  |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore Maryland</b>  |                         | 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 31 1972</b>   |                                     |  |  |
| 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor, M.D.</b>   |                         | 25C. FUNERAL DIRECTOR ADDRESS<br><b>Robert C. Altenburg Funeral Home, Inc. 6009 Harford Rd. - Balto., Md. 21214</b>   |                                     |  |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

| BALTIMORE CITY HEALTH DEPARTMENT   |                      |  |                                | 72 00991  |  | 72 00991   |   |
|--|----------------------|--|--------------------------------|---|--|--|---|
| CERTIFICATE OF DEATH   |                      |  |                                | X REG. NO.  |  |  |   |
| BIRTH NO. 4-625  |                      |  |                                | 1. NAME OF DECEASED (Type or Print) <u>HARKINS (MARIE) Jeanette C.</u>                |  | 2. DATE AND HOUR OF DEATH <u>1-25-72 9<sup>15</sup> P.</u>                                 |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |                      |  |                                | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) |  |  |   |
| FULL NAME OF HOSPITAL OR INSTITUTION (If not in hospital or institution, give street address or location)  |                      |  |                                | A. STATE <u>Maryland</u>  |  | B. COUNTY <u>Anne Arundle</u>  |   |
| <u>33 The Johns Hopkins Hospital</u>   |                      |  |                                | C. CITY OR TOWN <u>Baltimore</u>  |  | D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |   |
|  |                      |  |                                | E. STREET AND NUMBER <u>436 Outing Avenue</u>   |  | <u>PASADENA</u>  |   |
| 5. SEX <u>Female</u>   | 6. RACE <u>Cauc.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>                  | 8. DATE OF BIRTH <u>9/7/16</u> | 9. AGE (In years last birthday) <u>55</u>   | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) |  | 11. BIRTHPLACE (State or foreign country) |
|  |                      | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>                                     |                                |   | <u>Gen'l Housekeeping</u>  |  | <u>Maryland</u>                           |
| 10A. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)  |                      |  |                                | 10B. KIND OF BUSINESS OR INDUSTRY   |  | 12. CITIZEN OF WHAT COUNTRY?   |   |
| <u>Gen'l Housekeeping</u>  |                      |  |                                | <u>Anne Arundel Sch Bldg.</u>   |  | <u>USA</u>   |   |
| 13. FATHER'S NAME <u>William Henry Digman</u>  |                      |  |                                | 14. MOTHER'S MAIDEN NAME <u>Ella Lloyd</u>  |  |  |   |
| 15. Was Deceased Ever in U.S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service) <u>No</u>  |                      |  |                                | 16. SOCIAL SECURITY NO. <u>214-12-8623</u>  |  | 17. INFORMANT <u>Husband</u>   |   |
|  |                      |  |                                | ADDRESS <u>Charles R. Harkins 436 A Outing Ave. Pasadena</u>                          |  |  |   |
| 18. CAUSE OF DEATH   |                      |  |                                | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |  |   |
| DISEASE OR CONDITION DIRECTLY LEADING TO DEATH   |                      |  |                                | (A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF                                    |  | <u>Renal failure</u>   |   |
| (This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)  |                      |  |                                | (B) DUE TO, OR AS A CONSEQUENCE OF:   |  | <u>2 mos</u>   |   |
| ANTECEDENT CAUSES  |                      |  |                                | (C) <u>Alcoholic liver disease</u>  |  |  |   |
| DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                      |  |                                |   |  |  |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                      |  |                                |   |  |  |   |
| 19A. DATE OF OPERATION <u>2</u>  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |                                | 20A. AUTOPSY? (Yes or No) <u>YES</u>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>No</u>             |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |                                | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)              |  |  |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                      | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |                                | 21F. HOW DID INJURY OCCUR?  |  |  |   |
| 22. I certify that (1) (this hospital) attended the deceased from <u>12-29</u> 19 <u>71</u> to <u>1-25</u> 19 <u>72</u> that (2) (we) last saw the deceased alive on <u>1-25</u> 19 <u>72</u> and that in (3) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (4) (We) (did) (did not) view the body after death. |                      |  |                                |   |  |  |   |
| 23A. SIGNATURE <u>James F. Martin</u>  |                      |  |                                | 23B. DATE SIGNED <u>1-25-72</u>   |  |  |   |
| 23C. PHYSICIAN'S NAME (Type) <u>James F. Martin, M.D.</u>  |                      |  |                                | 23D. ADDRESS <u>The Johns Hopkins Hospital</u>  |  |  |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>   |                      | 24B. DATE <u>1/29/72</u>   |                                | 24C. NAME OF CEMETERY OR CREMATORY <u>Gardens of Faith Cem.</u>                       |  | 24D. LOCATION (City, town, or county) (State) <u>Overlea, Balto. Co. Maryland</u>          |   |
| 25A. DATE REC'D BY HEALTH DEPT. <u>JAN 31 1972</u>   |                      | 25B. NAME OF REGISTRAR <u>202 0.0 0</u>  |                                | 25C. FUNERAL DIRECTOR <u>Pasadena</u>   |  | ADDRESS <u>McDuff Funeral Home Mountain &amp; Tick Neck</u>                                |   |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |  |  |
|--|--|--|--|--|--|
| BALTIMORE CITY HEALTH DEPARTMENT   |  | 72 00992   |  | REG. NO.   |  |
| N-160  |  | 72 00992   |  | 72 00992   |  |
| BIRTH NO.  |  | 1. NAME OF DECEASED<br>(Type or Print)   |  | 2. DATE AND HOUR OF DEATH  |  |
|  |  | NAVARRO, ANTONIA   |  | 1-24-72 10 <sup>30</sup> a. M.   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION<br>(IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)   |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE<br>B. COUNTY   |  | 5. CITY OR TOWN  |  |
| JO. BALTO. GEN HOSPITAL<br>43  |  | Md. Balto  |  | 2834   |  |
| 6. SEX   |  | 7. RACE  |  | 8. DATE OF BIRTH   |  |
| F.   |  | W  |  | 72   |  |
| 9. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>   |  | 10. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>  |  | 11. AGE (in years last birthday)   |  |
|  |  |  |  | 72   |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)  |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 11. BIRTHPLACE (State or foreign country)                                |  |
|  |  |  |  | SPAIN  |  |
| 12. CITIZEN OF WHAT COUNTRY?   |  | 13. FATHER'S NAME  |  | 14. MOTHER'S MAIDEN NAME   |  |
| BOLIVIAN.  |  | ANTONIO PEIDRO   |  | ANTONIA RAFALEZ.   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)   |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT  |  |
|  |  |  |  | JULIO  |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |  | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>HEPATIC FAILURE<br>(B) OBSTRUCTION OF COMMON BILE DUCT.<br>(C) CHRONIC & ACUTE CHOLANGITIS |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH                             |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |  |  |  |  |  |
| 19A. DATE OF OPERATION   |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)  |  |
| Jan 10 and 15-72   |  | FOR (B) + RUPTURED COLON.  |  | NO   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)   |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location) |  |
|  |  |  |  |  |  |
| 21D. TIME OF INJURY (APPROX.)  |  | 21E. INJURY OCCURRED   |  | 21F. HOW DID INJURY OCCUR?   |  |
|  |  | While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from Jan 10 1972 to Jan 24 1972 that (I) (we) lost saw the deceased alive on 1/24 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.                         |  |  |  |  |  |
| 23A. SIGNATURE   |  | 23B. DATE SIGNED   |  |  |  |
| [Signature]  |  | 1/24-72  |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)   |  | 23D. ADDRESS   |  |  |  |
|  |  |  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)   |  | 24B. DATE  |  | 24C. NAME OF CEMETERY OR CREMATORY                                       |  |
| CREMATION  |  | 1-28-72  |  | LODON PARK CREMATORY   |  |
| 24D. LOCATION (City, town, or county) (State)  |  | 24E. DATE REC'D BY HEALTH DEPT.  |  | 24F. NAME OF REGISTRAR   |  |
| BALTIMORE MD   |  | JAN 31 1972  |  | KEYMONS O'FINIC - GLEN BURNIE, MD  |  |
| 24G. FUNERAL DIRECTOR  |  | 24H. ADDRESS   |  |  |  |
|  |  |  |  |  |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |  |  |  |  |  |   |  |
|--|--|--|--|--|--|---|--|
| W-424  |  | 72 00993   |  | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 72 00993   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Waelchli, Waelchli, CARL O.</b>  |  |  |  | 2. DATE AND HOUR OF DEATH<br><b>1-26-72 4:45 A.M.</b>  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived, if institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2605</b> |  |   |  |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>Baltimore City Hospitals</b><br><b>4940 Eastern Avenue Baltimore, Md. 21224</b>   |  | (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)                                   |  | C. CITY OR TOWN<br><b>BALTIMORE</b>  |  | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>   |  |
| E. STREET AND NUMBER<br><b>6607 Bushey St.</b>   |  | 5. SEX<br><b>Male</b>  |  | 6. RACE<br><b>Caucasian</b>  |  | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Body &amp; TENDER MAN</b>  |  | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Automotive</b>   |  | 8. DATE OF BIRTH<br><b>12-28-03</b>  |  | 9. AGE (In years last birthday)<br><b>68</b>  |  |
| 11. BIRTHPLACE (State or foreign country)<br><b>W. VA.</b>   |  | 12. CITIZEN OF WHAT COUNTRY?<br><b>U.S.A.</b>  |  | 13. FATHER'S NAME<br><b>OTTO Waelchli</b>  |  | 14. MOTHER'S MAIDEN NAME<br><b>VERNA HADORN</b>   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>UNKNOWN</b>   |  | 16. SOCIAL SECURITY NO.<br><b>233-09-4493</b>  |  | 17. INFORMANT<br><b>Records: BCH - 4940 Eastern Avenue Baltimore, Maryland 21224</b>   |  | ADDRESS   |  |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>372X 1-141.9</b><br>(This does not mean the mode of dying, e.g., heart failure, ashenia, etc. It means the disease, injury or complication which caused death.)<br><b>Bilateral Neurothoraces.</b>  |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH   |  |   |  |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.<br><b>II</b><br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).<br><b>19A. DATE OF OPERATION 1-19-72</b><br><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA of The tongue</b><br><b>20A. AUTOPSY? (Yes or No) Yes</b><br><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes</b> |  |  |  | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>LESS THAN 10 months</b>   |  |   |  |
| (B) <b>CARCINOMA of The tongue</b><br>DUE TO, OR AS A CONSEQUENCE OF:  |  |  |  | (C) _____  |  |   |  |
| MEDICAL CERTIFICATION  |  |  |  |  |  |   |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)               |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1-11-72</b> 19 to <b>1-26</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1-25</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.   |  |  |  |  |  |   |  |
| 23A. SIGNATURE<br><b>Francisco Jose Heerdi</b>   |  |  |  | 23B. DATE SIGNED<br><b>1-26-72</b>   |  |   |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>FRANCISCO JOSE HEERDI</b>   |  | 23D. ADDRESS<br><b>4940 Eastern Ave. Baltimore, Md. Baltimore City Hospitals 21224</b>                 |  |  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>  |  | 24B. DATE<br><b>1/29/72</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>Halcyon Hills Cemetery</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Sherrard, West Virginia</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 31 1972</b>  |  | 25B. NAME OF REGISTRAR<br><b>William D. Johnson</b>  |  | 25C. FUNERAL DIRECTOR<br><b>William D. Johnson</b>   |  | ADDRESS<br><b>8521 Loch Raven Blvd.</b>   |  |

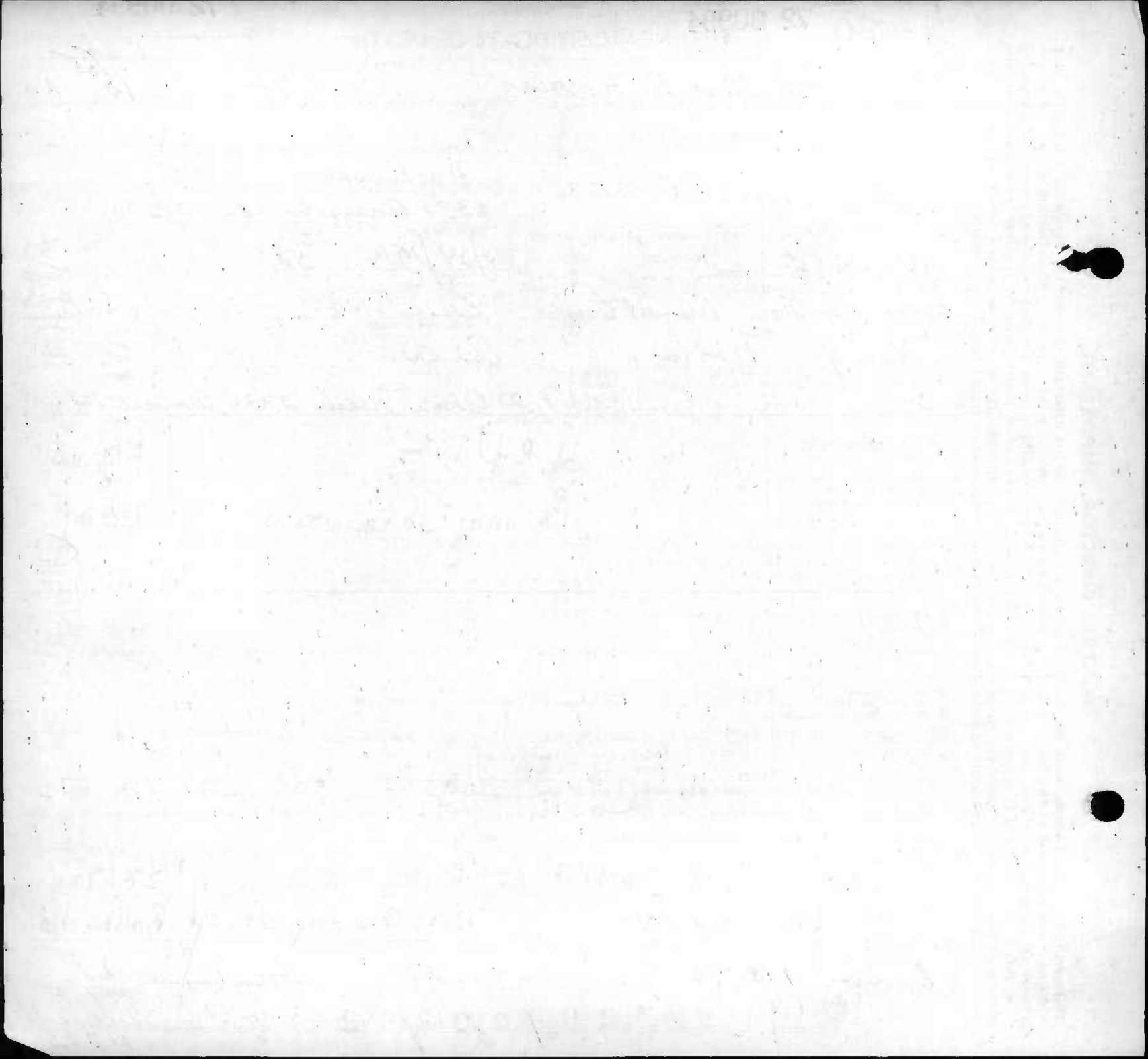




FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

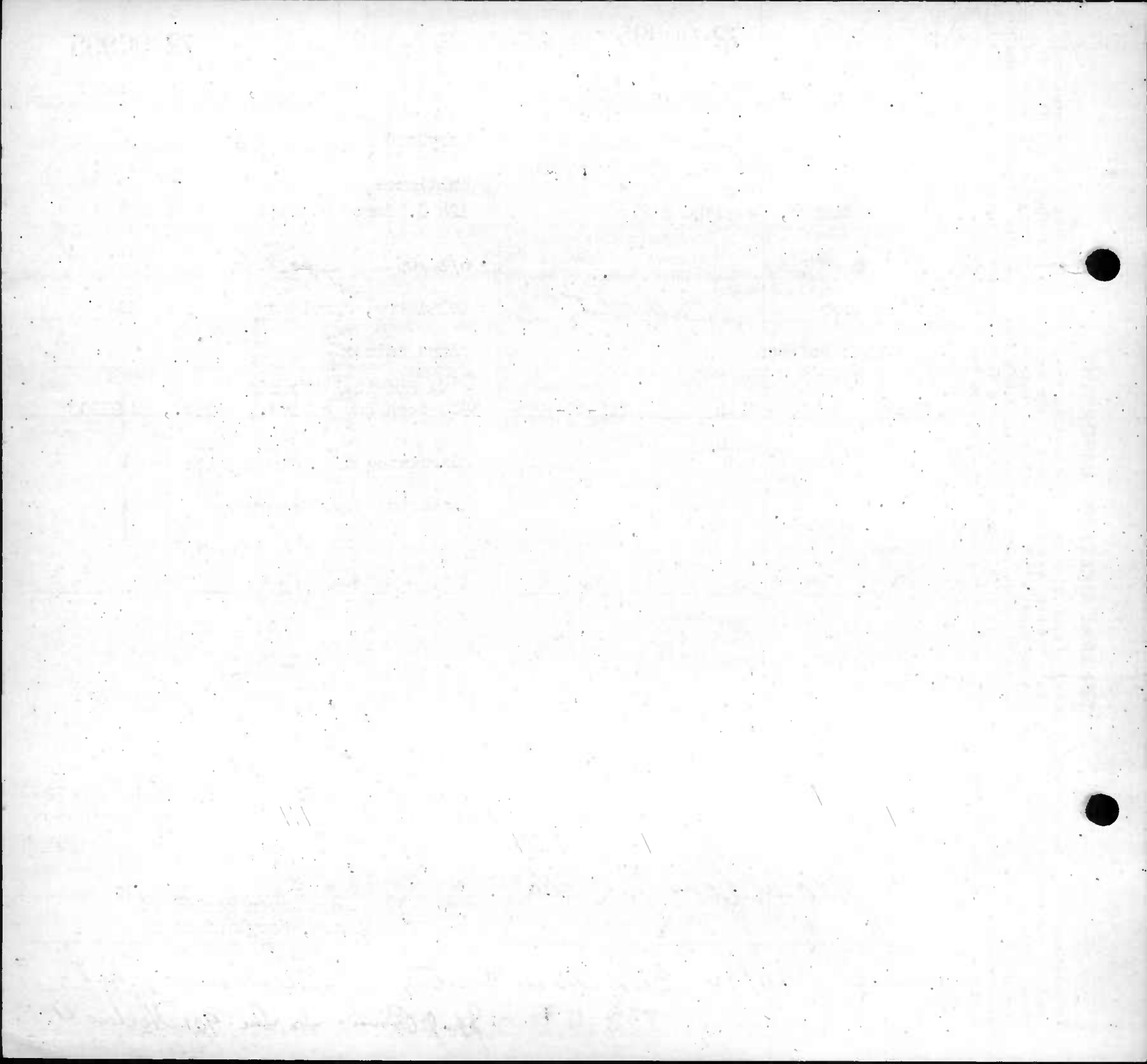
|  |  |   |  |   |  |
|--|--|---|--|---|--|
| <p><b>N-620 72 00994</b></p> <p><b>BIRTH NO.</b></p>   |  | <p><b>BALTIMORE CITY HEALTH DEPARTMENT</b></p> <p><b>CERTIFICATE OF DEATH</b></p>   |  | <p><b>72 00994</b></p> <p><b>REG. NO.</b></p>   |  |
| <p><b>1. NAME OF DECEASED</b><br/>(Type or Print)</p> <p><i>Walter R. Norris</i></p>   |  | <p><b>2. DATE AND HOUR OF DEATH</b></p> <p><i>1/28/72 10<sup>05</sup> A.M.</i></p>  |  |   |  |
| <p><b>3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD</b></p>   |  | <p><b>4. USUAL RESIDENCE</b> (Where deceased lived. If institution: residence before admission)<br/>A. STATE <i>md.</i> B. COUNTY <i>2533</i></p> |  |   |  |
| <p><b>FULL NAME OF HOSPITAL OR INSTITUTION</b> (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)</p> <p><i>2334 Annepolis Rd. 21230</i></p>   |  | <p><b>C. CITY OR TOWN</b><br/><i>Baltimore</i></p>  |  | <p><b>D. INSIDE CITY LIMITS?</b><br/>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p>  |  |
| <p><b>5. SEX</b><br/><i>Male</i></p>   |  | <p><b>6. RACE</b><br/><i>White</i></p>  |  | <p><b>7. MARRIED</b> <input checked="" type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/><br/><b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/></p> |  |
| <p><b>8. DATE OF BIRTH</b><br/><i>1/24/1914</i></p>  |  | <p><b>9. AGE</b> (In years last birthday)<br/><i>58</i></p>   |  | <p><b>10. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)<br/><i>Crane operator</i></p>  |  |
| <p><b>11. BIRTHPLACE</b> (State or foreign country)<br/><i>Baltimore, Md.</i></p>  |  | <p><b>12. CITIZEN OF WHAT COUNTRY?</b><br/><i>U.S.A.</i></p>  |  |   |  |
| <p><b>13. FATHER'S NAME</b><br/><i>Henry Norris</i></p>  |  | <p><b>14. MOTHER'S MAIDEN NAME</b><br/><i>Anna ?</i></p>  |  |   |  |
| <p><b>15. Was Deceased Ever in U. S. Armed Forces?</b><br/>(Yes, no or unknown) (If yes, give war or dates of service)<br/><i>No</i></p>   |  | <p><b>16. SOCIAL SECURITY NO.</b><br/><i>212-03-8222</i></p>  |  | <p><b>17. INFORMANT</b><br/><i>Alma Norris</i></p>  |  |
| <p><b>18. CAUSE OF DEATH</b></p> <p><i>410.01</i></p> <p><b>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH</b></p> <p>(This does not mean the mode of dying, e.g., heart failure, osthenia, etc. It means the disease, injury or complication which caused death.)</p> <p><b>ANTECEDENT CAUSES</b></p> <p>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.</p> <p><b>II</b></p> <p>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (A).</p> |  | <p><b>19. DATE OF OPERATION</b><br/><i>0</i></p>  |  | <p><b>19B. CONDITION FOR WHICH OPERATION WAS PERFORMED</b></p>  |  |
| <p><b>20A. AUTOPSY?</b> (Yes or No)<br/><i>No</i></p>  |  | <p><b>20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?</b></p>  |  |   |  |
| <p><b>21A. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (notify medical examiner)</p>  |  | <p><b>21B. PLACE OF INJURY</b> (e.g., in or about home, farm, factory, street, office bldg., etc.)</p>  |  | <p><b>21C. WHERE DID INJURY OCCUR?</b> (If in Baltimore City, give exact location)</p>  |  |
| <p><b>21D. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (APPROX.)</p>  |  | <p><b>21E. INJURY OCCURRED</b><br/>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/></p>                          |  | <p><b>21F. HOW DID INJURY OCCUR?</b></p>  |  |
| <p><b>22. I certify that (I) (this hospital) attended the deceased from</b> <i>Jan - 1950</i> <b>to</b> <i>Jan 28 1972</i>, <b>that (I) (we) last saw the deceased alive on</b> <i>Jan 26 1972</i> <b>and that (in) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.</b></p>   |  |   |  |   |  |
| <p><b>23A. SIGNATURE</b><br/><i>Paul Schufeldt MD</i></p>  |  | <p><b>23B. DATE SIGNED</b><br/><i>1/28/72</i></p>   |  | <p><b>23C. PHYSICIAN'S NAME</b> (Type)<br/><i>Paul Schufeldt</i></p>  |  |
| <p><b>23D. ADDRESS</b><br/><i>7301 Annepolis Rd Baltimore Md</i></p>   |  | <p><b>24A. BURIAL CREMATION, REMOVAL</b> (Specify)<br/><i>Burial</i></p>  |  |   |  |
| <p><b>24B. DATE</b><br/><i>1/31/72</i></p>   |  | <p><b>24C. NAME OF CEMETERY or CREMATORY</b><br/><i>Green Haven Cemetery</i></p>  |  | <p><b>24D. LOCATION</b> (City, town, or county) (State)<br/><i>Baltimore, Md.</i></p>   |  |
| <p><b>25A. DATE REC'D BY HEALTH DEPT.</b><br/><i>JAN 31 1972</i></p>   |  | <p><b>25B. NAME OF REGISTRAR</b><br/><i>John P. Schuman</i></p>   |  | <p><b>25C. FUNERAL DIRECTOR</b><br/><i>John P. Schuman &amp; Son Inc.</i></p>   |  |
| <p><b>25D. ADDRESS</b><br/><i>21223</i></p>  |  |   |  |   |  |



# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                         |   |  |
|---|-------------------------|---|--|
| BALTIMORE CITY HEALTH DEPARTMENT  |                         | REG. NO. <b>72 00995</b>  |  |
| BIRTH NO. <b>4-155</b>  |                         | <b>72 00995</b> CERTIFICATE OF DEATH  |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>HOFFMAN, AUGUST J</b>   |                         | 2. DATE AND HOUR OF DEATH<br><b>January 26, 1972   5:00 P M.</b>  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD  |                         | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>1902</b>                  |  |
| FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>23 Veterans administration Hospital</b><br><b>3900 Loch Raven Boulevard</b><br><b>Baltimore, Maryland 21218</b>   |                         | C. CITY OR TOWN <b>Baltimore</b><br>D. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>                              |  |
| E. STREET AND NUMBER<br><b>124 S. Carey S treet - 21223</b>   |                         |   |  |
| 5. SEX<br><b>Male</b>   | 6. RACE<br><b>White</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>6/20/05</b>           |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Laborer</b>   |                         | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Balt. City</b>  | 9. AGE (In years last birthday)<br><b>66</b> |
| 11. BIRTHPLACE (State or foreign country)<br><b>Baltimore, Maryland</b>   |                         | 12. CITIZEN OF WHAT COUNTRY?<br><b>USA</b>  |  |
| 13. FATHER'S NAME<br><b>Frank Hoffman</b>   |                         | 14. MOTHER'S MAIDEN NAME<br><b>Anna Kaizer</b>  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes 1942 to 1944</b>   |                         | 16. SOCIAL SECURITY NO.<br><b>212-12-6995</b>   |  |
| 17. INFORMANT<br><b>VA Hospital Records</b>   |                         | ADDRESS<br><b>3900 Loch Raven Blvd., Balto., Md 21218</b>   |  |
| 18. <b>157.9 I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, oshtenio, etc. It means the disease, injury or complication which caused death.)<br><b>CAUSE OF DEATH</b><br>(A) IMMEDIATE CAUSE <b>Carcinoma of pancreas with</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>metastases to mesentery</b><br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C) _____ |                         | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH  |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br>_____   |                         |   |  |
| 19A. DATE OF OPERATION<br><b>2</b>  |                         | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |  |
| 20A. AUTOPSY? (Yes or No)<br><b>YES</b>   |                         | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?<br><b>Yes</b>  |  |
| 21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (notify medical examiner)   |                         | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |  |
| 21C. WHERE DID INJURY OCCUR?<br>(If in Baltimore City, give exact location)   |                         |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                         | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |  |
| 21F. HOW DID INJURY OCCUR?  |                         |   |  |
| 22. I certify that <b>(1)</b> (this hospital) attended the deceased from <b>December 1st 1971</b> to <b>January 26th 1972</b> , that <b>(1)</b> (we) last saw the deceased alive on <b>January 26th 1972</b> and that in <b>(1)</b> (our) opinion death occurred on the date and hour and from the causes stated above. <b>(1)</b> (We) (did) <b>(1)</b> (not) view the body after death.                                       |                         |   |  |
| 23A. SIGNATURE<br><b>Monell Hoaguel</b>   |                         | 23B. DATE SIGNED<br><b>1/28/72</b>  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Monell Hoaguel</b>   |                         | 23D. ADDRESS<br><b>3900 Loch Raven Boulevard</b><br><b>Baltimore, Maryland 21218</b>  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>burial</b>   |                         | 24B. DATE<br><b>1/31/72</b>   |  |
| 24C. NAME OF CEMETERY OR CREMATORY<br><b>Glen Haven Cemetery</b>  |                         | 24D. LOCATION (City, town, or county) (State)<br><b>Glenburne, Ind.</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 31 1972</b>   |                         | 25B. NAME OF REGISTRAR<br><b>2000</b>   |  |
| 25C. FUNERAL DIRECTOR<br><b>John P. Conway</b>  |                         | ADDRESS<br><b>901 Hollins St.</b><br><b>Balt Md 21223</b>   |  |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                      |   |   |   |   |
|---|----------------------|---|---|---|---|
| C-463 72 00996  |                      | BALTIMORE CITY HEALTH DEPARTMENT  |   | 72 00996  |   |
| BIRTH NO.   |                      | CERTIFICATE OF DEATH  |   | REG. NO.  |   |
| 1. NAME OF DECEASED<br>(Type or Print)<br><b>Raymond Edward Clark</b>   |                      |   | 2. DATE AND HOUR OF DEATH<br><b>1-22-72 6:10 P.M.</b>   |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>Hood Convalescent Home<br/>5313 Edmondson Ave<br/>Balto. Md. 21229</b>  |                      |   | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>md.</b> B. COUNTY <b>Balto.</b><br>C. CITY OR TOWN <b>Ellicott City</b> D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER <b>8934 Old Frederick Rd. 21043</b> |   |   |
| 5. SEX<br><b>male</b>   | 6. RACE<br><b>W.</b> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>10-10-1904</b>   | 9. AGE (in years last birthday)<br><b>67</b>  | 10. If Under 1 Yr. Months Days If Under 24 Hrs. Hours Min.                        |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>GARDNER</b>   |                      | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>FARM.</b>   |   | 11. BIRTHPLACE (State or foreign country)<br><b>Maryland</b>  |   |
| 13. FATHER'S NAME<br><b>George Clark</b>  |                      |   | 14. MOTHER'S MAIDEN NAME<br><b>SARAH DAVIS</b>  |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>No</b>   |                      | 16. SOCIAL SECURITY NO.<br><b>220-48-4341</b>   |   | 17. INFORMANT<br><b>Shirley Bosom</b> ADDRESS<br><b>8934 Old Frederick Rd. Ellicott City Md 21043</b> |   |
| 18. <b>188X I</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.   |                      |   | (A) IMMEDIATE CAUSE<br><b>CARDIOPALMONIC ARREST</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>&amp; GENERALIZED METASTASIS</b><br>(B) <b>PNEUMONIA</b><br>DUE TO, OR AS A CONSEQUENCE OF:<br>(C) <b>A.C.V.D.</b>   |   |   |
| OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                      |   |   |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                      | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |   | 20A. AUTOPSY? (Yes or No) <b>No</b>   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                      | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                              |   |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |                      | 21E. INJURY OCCURRED<br>While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>   |   | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from <b>1/21</b> 19 <b>71</b> to <b>1/22</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/21</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                      |   |   |   |   |
| 23A. SIGNATURE<br><b>John H. Shaw</b> M.D.  |                      |   | 23B. DATE SIGNED<br><b>1/23/72</b>  |   | 23C. PHYSICIAN'S NAME (Type)<br><b>John H. Shaw</b>                               |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                      |   | 24B. DATE<br><b>1-25-72</b>   |   | 24C. NAME OF CEMETERY or CREMATORY<br><b>Good Shepherd</b>                        |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 31 1972</b>   |                      |   | 25B. NAME OF REGISTRAR<br><b>Shirley Bosom</b>  |   | 25C. FUNERAL DIRECTOR<br><b>SHIRLEY BOSOM</b> ADDRESS<br><b>Ellicott City Md.</b> |

1898

1898

1898

1898

1898

1898

1898

1898

1898

1898

1898

1898

1898

1898

1898

1898

1898

1898

1898

1898

1898

1898

1898

## CERTIFICATE OF DEATH

**BIRTH NO.** 72 00997

**1. NAME OF DECEASED** (Type or Print) ALICE K. SINKIEWICZ (SYNOSKI)

**2. DATE AND HOUR OF DEATH** January 29 1972 2:17 P.M.

**3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD**

**FULL NAME OF HOSPITAL OR INSTITUTION** (If not in hospital or institution, give street address or location) Baltimore City Hospitals  
4940 Eastern Ave. Baltimore, Md. 21224

**4. USUAL RESIDENCE** (Where deceased lived. If institution: residence before admission)  
A. STATE MARYLAND B. COUNTY 2608

**5. SEX** Female **6. RACE** Caucasian **7. MARRIED** ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

**8. DATE OF BIRTH** 3-15-1897 **9. AGE** (in years last birthday) 80 **10. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) None Housewife **11. BIRTHPLACE** (State or foreign country) POLAND **12. CITIZEN OF WHAT COUNTRY?**

**13. FATHER'S NAME** **14. MOTHER'S MAIDEN NAME**

**15. Was Deceased Ever in U. S. Armed Forces?** (Yes, no or unknown) (If yes, give war or dates of service) **16. SOCIAL SECURITY NO.** 212-10-1714-G **17. INFORMANT** 4940 Eastern Ave. ADDRESS BCH Records: Baltimore, Md. 21224

**18. CAUSE OF DEATH**

**DISEASE OR CONDITION DIRECTLY LEADING TO DEATH** (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.) Cerebral vascular accident

**ANTECEDENT CAUSES** DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.

**(A) IMMEDIATE CAUSE DUE TO, OR AS A CONSEQUENCE OF:** 10 days

**(B) DUE TO, OR AS A CONSEQUENCE OF:**

**(C) DUE TO, OR AS A CONSEQUENCE OF:**

**II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).**

**19A. DATE OF OPERATION** **19B. CONDITION FOR WHICH OPERATION WAS PERFORMED** **20A. AUTOPSY?** (Yes or No) NO **20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?**

**21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH** (notify medical examiner) **21B. PLACE OF INJURY** (e.g., in or about home, farm, factory, street, office bldg., etc.) **21C. WHERE DID INJURY OCCUR?** (If in Baltimore City, give exact location)

**21D. TIME OF INJURY (APPROX.)** (Month) (Day) (Year) (Hour) **21E. INJURY OCCURRED** While At Work ☐ Not While At Work ☐ **21F. HOW DID INJURY OCCUR?**

**22. I certify that** (this hospital) attended the deceased from JANUARY 24 1972 to JANUARY 29 1972 that (we) last saw the deceased alive on JANUARY 29 1972 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.

**23A. SIGNATURE** **23B. DATE SIGNED** Jan. 29 1972

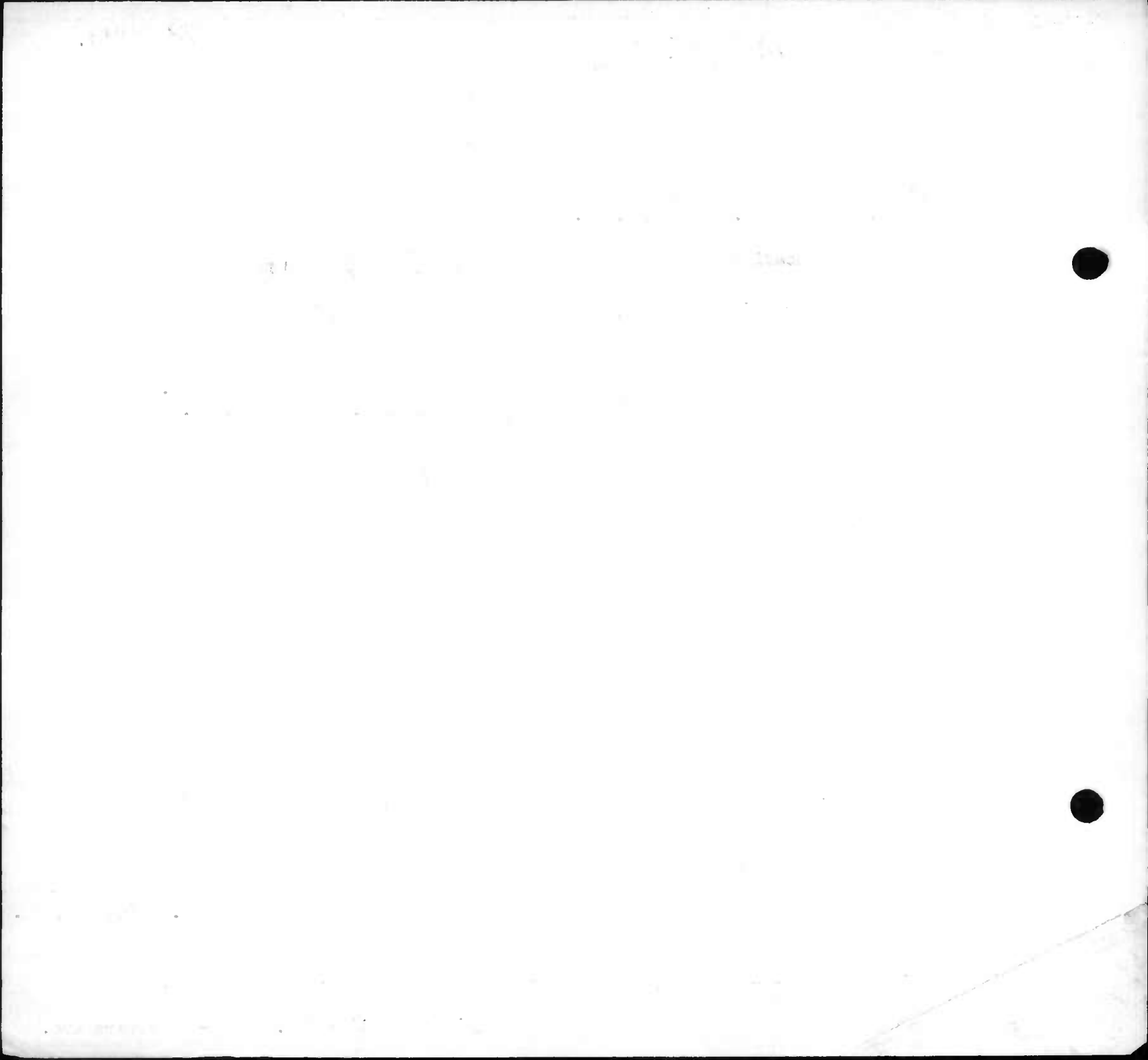
**23C. PHYSICIAN'S NAME** (Type) A. Z. MAKARY M.D. **23D. ADDRESS** 4940 Eastern Ave. Baltimore, Md.

**24A. BURIAL CREMATION, REMOVAL** (Specify) Burial **24B. DATE** 2-2-1972 **24C. NAME OF CEMETERY OR CREMATORY** Gardens of Faith **24D. LOCATION** (City, town, or county) (State) Baltimore County, Maryland

**25A. DATE REC'D BY HEALTH DEPT.** JAN 31 1972 **25B. NAME OF REGISTRAR** **25C. FUNERAL DIRECTOR** Gilly & Zeller Inc. 1901-07 Eastern Ave.

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.





MAK

FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|  |                  |   |   |  |  |   |  |
|--|------------------|---|---|--|--|---|--|
| B-650  |                  | 72 00998  |   | BALTIMORE CITY HEALTH DEPARTMENT   |  | REG. NO. 72 00998   |  |
| BIRTH NO.  |                  |   |   | 1  |  |   |  |
| 1. NAME OF DECEASED<br>(Type or Print) BROWN, DOROTHY LOUISE (WILLIAMS)  |                  |   |   | 2. DATE AND HOUR OF DEATH<br>JANUARY 25, 1972 6:30 P.M.  |  |   |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br>40 ST. AGNES HOSPITAL<br>CATON & WILKENS AVE  |                  |   |   | 4. USUAL RESIDENCE (Where deceased lived, if institution residence before admission)<br>A. STATE MARYLAND B. COUNTY BALTIMORE<br>C. CITY OR TOWN BALTIMORE D. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/><br>E. STREET AND NUMBER 202 WINTERS LANE 21228 |  |   |  |
| 5. SEX<br>FEMALE   | 6. RACE<br>NEGRO | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | 8. DATE OF BIRTH<br>11 26 12              | 9. AGE (In years last birthday) 59   | If Under 1 Yr. Months: Days:   | If Under 24 Hrs. Hours: Min.  |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br>HOUSEWIFE   |                  |   | 10B. KIND OF BUSINESS OR INDUSTRY         |  | 11. BIRTHPLACE (State or foreign country)<br>MARYLAND                                |   | 12. CITIZEN OF WHAT COUNTRY?<br>U.S.A. |
| 13. FATHER'S NAME<br>CHARLES BROWN   |                  |   | 14. MOTHER'S MAIDEN NAME<br>SARAH ROLLINS |  |  |   |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br>NO   |                  |   | 16. SOCIAL SECURITY NO.<br>213 12 4757    |  | 17. INFORMANT BALTIMORE MARYLAND ADDRESS 21229 ST AGNES HOSPITAL CATON & WILKENS AVE |   |  |
| 18. 154.11<br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)<br>PULMONARY EMBOLISM<br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last. |                  |   |   | CAUSE OF DEATH<br>(A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br>(B) DUE TO, OR AS A CONSEQUENCE OF:<br>(C)   |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br>1 days.   |  |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).   |                  |   |   |  |  |   |  |
| 19A. DATE OF OPERATION<br>JAN 21, 1972   |                  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED<br>CANCER OF RECTUM  |   | 20A. AUTOPSY? (Yes or No)<br>NO  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)  |                  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |   | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)   |  |   |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)  |                  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |   | 21F. HOW DID INJURY OCCUR?   |  |   |  |
| 22. I certify that (X) (this hospital) attended the deceased from JANUARY 6 19 72 to JANUARY 25 19 72 that (X) (we) lost saw the deceased alive on JANUARY 25 19 72 and that (XX) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (We) (did) (did not) view the body after death.  |                  |   |   |  |  |   |  |
| 23A. SIGNATURE<br>Sunthorn Malaisrie MD  |                  |   |   | 23B. DATE SIGNED<br>JAN 25, 1972   |  | Attending Phys. <input type="checkbox"/> Med. Director <input type="checkbox"/> Staff Phys. <input checked="" type="checkbox"/> |  |
| 23C. PHYSICIAN'S NAME (Type)<br>SUNTHORN MALAISRIE MD  |                  |   |   | 23D. ADDRESS<br>St. Agnes Hosp.  |  |   |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br>BURIAL   |                  | 24B. DATE<br>1-29-72  |   | 24C. NAME OF CEMETERY OR CREMATORY<br>WESTERN STAR   |  | 24D. LOCATION (City, town, or county) (State)<br>BALTIMORE, MARYLAND  |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br>JAN 31 1972   |                  | 25B. NAME OF REGISTRAR<br>Mary-Elizabeth Law  |   | 25C. FUNERAL DIRECTOR<br>MARY-ELIZABETH LAW  |  | ADDRESS<br>802 MADISON AVE.   |  |

2000

1000

1000

1000

1000

1000

1000

1000

1000

1000

1000

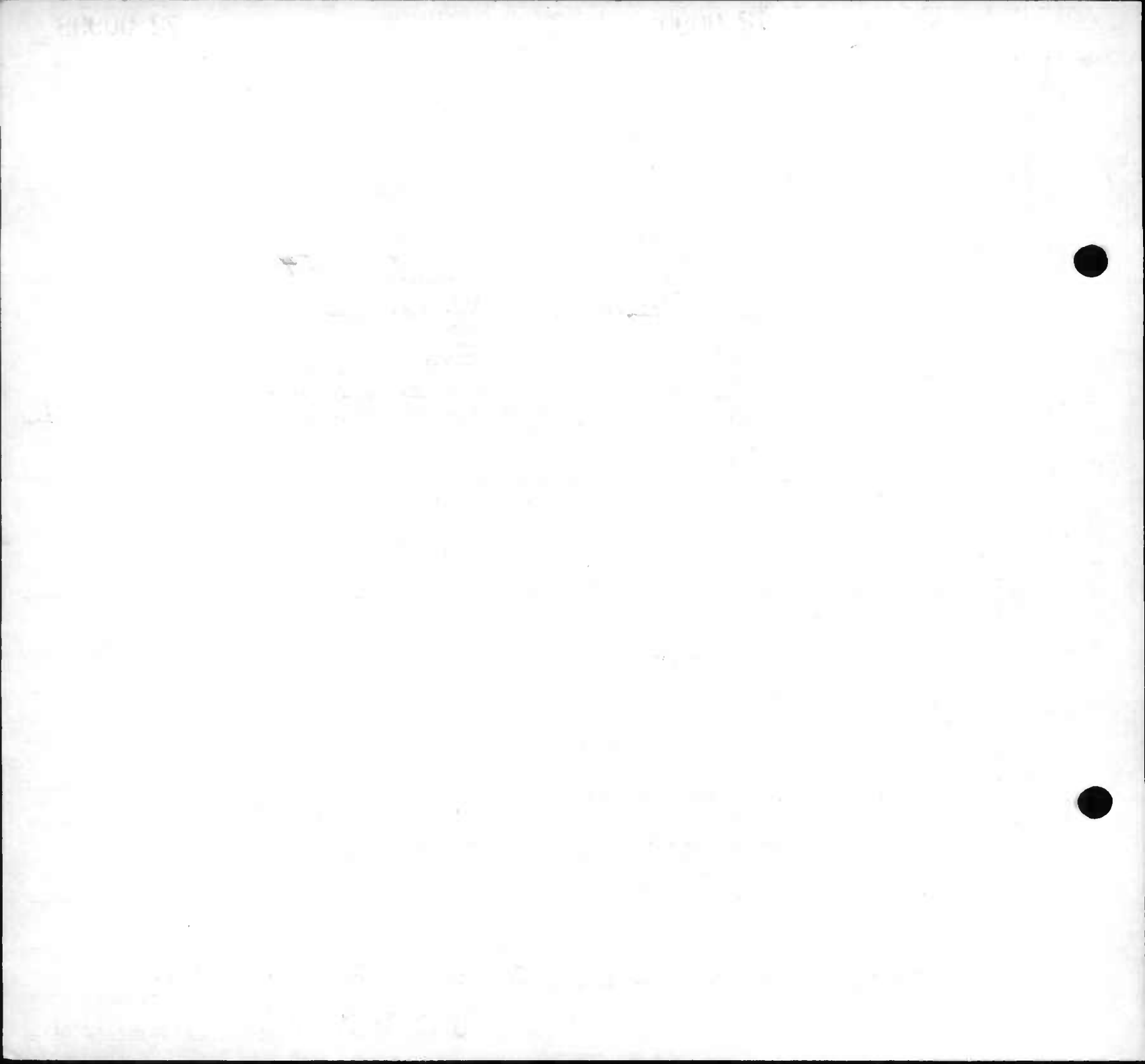
1000

1000

# FUNERAL DIRECTOR: IMPORTANT

This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |                             |   |                                     |   |   |
|---|-----------------------------|---|-------------------------------------|---|---|
| 72 00999  |                             | BALTIMORE CITY HEALTH DEPARTMENT  |                                     | 72 00999  |   |
| M-212   |                             | CERTIFICATE OF DEATH  |                                     | REG. NO.  |   |
| 1. NAME OF DECEASED<br>(Type or Print) <b>McVICKER, HERBERT</b>   |                             | 2. DATE AND HOUR OF DEATH<br><b>1/25/72 5:44/pm</b>   |                                     |   |   |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><b>CHURCH HOME AND HOSPITAL</b>   |                             | 4. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)<br>A. STATE <b>MARYLAND</b><br>B. COUNTY <b>102</b>                   |                                     |   |   |
| FULL NAME OF HOSPITAL OR INSTITUTION<br><b>35</b>   |                             | C. CITY OR TOWN<br><b>BALTIMORE</b>   |                                     | D. INSIDE CITY LIMITS?<br>YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |   |
| (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)  |                             | E. STREET AND NUMBER<br><b>528 S STREEPER ST. 21224</b>   |                                     |   |   |
| 5. SEX<br><b>MALE</b>   | 6. RACE<br><b>CAUCASIAN</b> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH<br><b>11/22/17</b> | 9. AGE (In years last birthday)<br><b>54</b>  | 10. Under 1 Yr. Months: Days: 11. Under 24 Hrs. Hours: Min. |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)<br><b>Foreman</b>   |                             | 10B. KIND OF BUSINESS OR INDUSTRY<br><b>Closure</b>   |                                     | 11. BIRTHPLACE (State or foreign country)<br><b>W. Va.</b>                                    |   |
| 12. CITIZEN OF WHAT COUNTRY?<br><b>AMERICA</b>  |                             |   |                                     |   |   |
| 13. FATHER'S NAME<br><b>George McVicker</b>   |                             | 14. MOTHER'S MAIDEN NAME<br><b>Eva Skaggs</b>   |                                     |   |   |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)<br><b>Yes W. W. II</b>   |                             | 16. SOCIAL SECURITY NO.<br><b>235-146893</b>  |                                     | 17. INFORMANT ADDRESS<br><b>Mrs. Irene McVicker 538 S. Streepier St., Baltimore Md.</b>       |   |
| 18. DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br><b>154.01</b>   |                             | CAUSE OF DEATH<br><b>Carcinoma, recto-sigmoid</b>   |                                     | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>one year</b>                               |   |
| (This does not mean the mode of dying, e.g., heart failure, asphyxia, etc. It means the disease, injury or complication which caused death.)  |                             | (A) IMMEDIATE CAUSE<br>DUE TO, OR AS A CONSEQUENCE OF:<br><b>NOTE: INFORMATION OBTAINED FROM DR. WM. LUMPKIN</b>  |                                     |   |   |
| ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION last.  |                             | (B) DUE TO, OR AS A CONSEQUENCE OF:<br><b>Pulmonary Emphysema</b>   |                                     | <b>years</b>  |   |
| (C)   |                             |   |                                     |   |   |
| II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).  |                             |   |                                     |   |   |
| 19A. DATE OF OPERATION<br><b>0</b>  |                             | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED  |                                     | 20A. AUTOPSY? (Yes or No)<br><b>No</b>  |   |
| 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?  |                             |   |                                     |   |   |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (notify medical examiner)   |                             | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)  |                                     | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)                      |   |
| 21D. TIME OF INJURY (Month) (Day) (Year) (Hour) (Approx.)   |                             | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>  |                                     | 21F. HOW DID INJURY OCCUR?  |   |
| 22. I certify that (I) (this hospital) attended the deceased from _____ 19____ to _____ 19____<br>that (I) (we) last saw the deceased alive on <b>DOA</b> _____ 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death. |                             |   |                                     |   |   |
| 23A. SIGNATURE<br><b>Manuel A. Gongon, M.D.</b>   |                             | 23B. DATE SIGNED<br><b>1/25/72</b>  |                                     |   |   |
| 23C. PHYSICIAN'S NAME (Type)<br><b>MANUEL A. GONGON, M.D.</b>   |                             | 23D. ADDRESS<br><b>100 N. BROADWAY, BALTO., MD.</b>   |                                     |   |   |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>BURIAL</b>   |                             | 24B. DATE<br><b>1-29-72</b>   |                                     | 24C. NAME OF CEMETERY OR CREMATORY<br><b>Oak Lawn Cemetery</b>                                |   |
| 24D. LOCATION (City, town, or county) (State)<br><b>Baltimore, Md.</b>  |                             |   |                                     |   |   |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 31 1972</b>   |                             | 25B. NAME OF REGISTRAR<br><b>Robert E. Taylor</b>   |                                     | 25C. FUNERAL DIRECTOR<br><b>Nicholas J. Matthews</b>  |   |
|   |                             |   |                                     | ADDRESS<br><b>3021 Eastern Ave., Baltimore, Md.</b>   |   |



This certificate must be approved by the chief medical examiner or his assistant if death occurred in a hospital and the body was released to the hospital by a medical examiner. Also, if the direct or contributing cause of death shows: (1) An accident of any nature; (2) Body burns; (3) A fracture of any kind; (4) Undetermined cause; (5) Deceased was D.O.A. at a hospital (except where the physician who pronounced death was in regular attendance on the deceased prior to death); and (6) No physician was in regular attendance on the deceased prior to death. Such written approval must be obtained before the remains are embalmed or final disposition is made.

|   |  |  |  |   |  |  |  |
|---|--|--|--|---|--|--|--|
| BIRTH NO. <b>M-140</b>  |  | 72 01000   |  | BALTIMORE CITY HEALTH DEPARTMENT  |  | REG. NO. <b>72 01000</b>   |  |
| 1. NAME OF DECEASED<br>(Type or Print) <b>Margaret Mobley (Lobley)</b>  |  |  |  | 2. DATE AND HOUR OF DEATH<br><b>January 20, 1972   6:00 p.m.</b>  |  |  |  |
| 3. PLACE IN BALTIMORE, MARYLAND, WHERE PRONOUNCED DEAD<br><br>FULL NAME OF HOSPITAL OR INSTITUTION (IF NOT IN HOSPITAL OR INSTITUTION, GIVE STREET ADDRESS OR LOCATION)<br><b>31 Baltimore City Hospitals<br/>4940 Eastern Avenue<br/>Baltimore, Maryland 21224</b>   |  |  |  | 4. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)<br>A. STATE <b>Maryland</b><br>B. COUNTY <b>2301</b>                  |  |  |  |
| 5. SEX<br><b>Female</b>   |  | 6. RACE<br><b>Negro</b>  |  | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/><br>WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> |  | 8. DATE OF BIRTH<br><b>4-22-1909</b>                                 |  |
| 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)   |  | 10B. KIND OF BUSINESS OR INDUSTRY  |  | 9. AGE (In years lost birthday) <b>62</b>   |  | 11. BIRTHPLACE (State or foreign country)<br><b>North Carolina</b>   |  |
| 13. FATHER'S NAME   |  |  |  | 14. MOTHER'S MAIDEN NAME  |  |  |  |
| 15. Was Deceased Ever in U. S. Armed Forces? (Yes, no or unknown) (If yes, give war or dates of service)  |  | 16. SOCIAL SECURITY NO.  |  | 17. INFORMANT<br><b>BCH RECORDS:</b>  |  | ADDRESS<br><b>4940 Eastern Avenue<br/>Baltimore, Maryland 21224</b>  |  |
| 18. <b>412.41X182.0</b><br>DISEASE OR CONDITION DIRECTLY LEADING TO DEATH<br>(This does not mean the mode of dying, e.g., heart failure, asthma, etc. It means the disease, injury or complication which caused death.)<br><b>Pneumonia</b><br>ANTECEDENT CAUSES<br>DISEASES OR CONDITIONS, if any, giving rise to the above cause (A) stating the UNDERLYING CONDITION lost.<br><b>Cerebrovascular Accident</b><br>II<br>OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (A).<br><b>ASCD</b><br><b>Admission of a doctor</b> |  |  |  | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH<br><b>2 WEEKS</b><br><b>2 MONTHS</b>   |  |  |  |
| 19A. DATE OF OPERATION  |  | 19B. CONDITION FOR WHICH OPERATION WAS PERFORMED   |  | 20A. AUTOPSY? (Yes or No)<br><b>NO</b>  |  | 20B. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |  |
| 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (Notify medical examiner) <b>NO</b>   |  | 21B. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg, etc.)                |  | 21C. WHERE DID INJURY OCCUR? (If in Baltimore City, give exact location)  |  |  |  |
| 21D. TIME OF INJURY (APPROX.) (Month) (Day) (Year) (Hour)   |  | 21E. INJURY OCCURRED While At Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> |  | 21F. HOW DID INJURY OCCUR?  |  |  |  |
| 22. I certify that (I) (this hospital) attended the deceased from <b>12/29</b> 19 <b>71</b> to <b>1/20</b> 19 <b>72</b> that (I) (we) last saw the deceased alive on <b>1/20</b> 19 <b>72</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.  |  |  |  |   |  |  |  |
| 23A. SIGNATURE<br><b>Robert L. Ruxin</b>  |  |  |  | 23B. DATE SIGNED<br><b>1/20/72</b>  |  |  |  |
| 23C. PHYSICIAN'S NAME (Type)<br><b>Robert L. Ruxin</b>  |  |  |  | 23D. ADDRESS<br><b>4940 Eastern Avenue<br/>Baltimore, Maryland 21224</b>  |  |  |  |
| 24A. BURIAL CREMATION, REMOVAL (Specify)<br><b>Burial</b>   |  | 24B. DATE<br><b>1/25/72</b>  |  | 24C. NAME OF CEMETERY or CREMATORY<br><b>mt Auburn</b>  |  | 24D. LOCATION (City, town, or county) (State)<br><b>Balto City</b>   |  |
| 25A. DATE REC'D BY HEALTH DEPT.<br><b>JAN 31 1972</b>   |  | 25B. NAME OF REGISTRAR<br><b>Blair Brown</b>   |  | 25C. FUNERAL DIRECTOR<br><b>1202 N. Mount Vernon</b>  |  | ADDRESS<br><b>1202 N. Mount Vernon</b>                               |  |

